

**An analysis of parents' experience of parenthood and
of the health visiting service, from the perspectives of
parents of young children**

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ABSTRACT

The study set out to explore and interpret parents' experience of parenthood and of the health visiting service from the perspectives of parents of young children. A phenomenological approach was adopted. Data obtained from semi-structured interviews and small group discussions were analysed thematically and subsequently interpreted using a theoretical framework based on Lazarus and Folkman's (1984) theory of stress and coping, family nursing theory and Bandura's (1977, 1982) theories of social learning.

The study findings suggest that parenthood is associated with an overwhelming sense of responsibility to children and to society. Extended family is presented as a very limited source of practical help and useful advice in relation to childrearing and the establishment of new social networks seems to be vital for many parents in coping with the challenges of childrearing. Parents demonstrated an awareness of their unique understanding of their own child. The transition to parenthood is portrayed as especially problematic for many parents.

Many parents appear to believe that health visitors have a duty to monitor the welfare of all children. Many parents, however, described their own health visitors as providing them with support and encouragement and as having a role in substituting to some degree for support and advice which traditionally might have come from parents' own social network of family and friends. The health visiting service was also portrayed as an important source of advice to some parents who had good social support, as a resource for help with problems which could not be resolved with help from informal sources, or which involved relationships with others and were considered by parents to require help from an unbiased outsider who could assure confidentiality. While the health visitor's role with families in the early days of parenthood was generally well understood, parents' recognition of the wider remit of the health visiting service often depended on personal or second-hand experience of health visitors providing more holistic care. Caring, as defined by Leininger (1991) emerged from analysis of the data as being an important aspect of the health visitor's role with families.

The study findings support the continuation of health visiting as a universal service rather than restricting the provision of advice and support to families assessed as being in greatest need. It appears that many parents do not fully understand the role of health visitors and recommendations for improving this situation are made. The need for future research into alternative ways of providing support to parents, using, for example, skill mix and community development approaches, is identified.

Declaration

I hereby declare that this thesis has been composed by myself and that the research on which it reports is my own work.

Rhona Hogg

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CHAPTER 1: INTRODUCTION

1.1 Background to the study

The study from which this thesis originates formed part of a Research Training Fellowship, funded jointly by what was then known as the Scottish Office and the local primary care NHS trust, which I undertook from 1996-1998 at the Department of Nursing Studies at the University of Edinburgh. The thesis uses data from the study (Hogg and Worth 1998) which used both qualitative and quantitative methods to evaluate the effectiveness of the Child Development Programme (Barker 1987).

At the time the study was planned, there was debate about the health visiting role in general and particularly about whether the service should be targeted at families in need rather than being provided universally (Audit Commission 1994). The study therefore was concerned with exploring parents' perceptions of 'normal' parenthood and of their experience of 'routine' health visiting.

An examination of health visiting in relation to families with young children must be set within the current social and political context, as an effective health visiting service must adapt to changing influences on parents and parenting. The history of the health visiting service reflects such responses to social change (Abbott and Wallace 1998), the focus at the beginning of this century on addressing poor hygiene, poor nutrition and poverty being gradually replaced by a much broader range of health visiting interventions centred on child development. Changes in family life in the latter half of the 20th century, with reorganised, single parent and dual-earner families becoming increasingly common (The Home Office 1998), have raised questions about the continued relevance of health visiting policy to contemporary mothers (Machen 1996). Furthermore, changed expectations of family life and parenting, including the decreasing acceptability of physical punishment, and of professional-client relationships, with partnership rather than professionally-dominated approaches advocated (Twinn 1991; Kendall 1993), require health visitors to adapt their approach accordingly.

During the time the study was undertaken there was a change of government with an increasing political interest in helping parents in their role (Home Office 1998), which appeared to strengthen the case for maintaining health visiting as a universal service.

It therefore seemed timely to look at the role of the health visiting service in the context of contemporary parenthood in order to gain an understanding of the work of the health visiting service with families with young children who were unlikely to meet the criteria for more targeted health visiting interventions.

1.2 The experience of parenthood

Parenthood has an extreme tension at the centre of it: it is both a very ordinary thing to do and utterly extraordinary. Most people do it, and beginning the process is not usually difficult. It begins one life, and drastically changes the lives of at least one or two others. Parenthood is a skilled and necessary job which attracts no income and minimal recognition.

The dichotomy between good and bad parents influences how parents see themselves and are seen. Parents who are judged to have got it wrong are subjected to public hatred: the parents of the boys who killed Jamie Bulger; mothers who go on holiday and leave their children 'home alone'; mothers who walk out. Good parents, however, are only as they should be.

There is a tension between viewing family life as a private experience and as a focus for public debate and public policy (Rodger 1996). Broderick (1993) uses the analogy of Goffman's (1959) observation of 'front-stage' and 'back-stage' activities in hotels. The study set out to portray the private lives of families, with the acknowledgement that the accounts of parents are a public portrayal, and not necessarily a true representation, of their lives.

The main discourse around parenthood in the twentieth century has been the change of emphasis from parents' role as simply providing for children's physical health and well-being to their being crucial to children's emotional and cognitive progress

(Chodorow 1978). Despite decreasing family size, parenthood has gained a new significance.

At the beginning of the twentieth century parenting had already come under the influence of experts, principally the medical profession. Mothers were advised to impose a regime of strict routine and discipline upon themselves and their children.

The failure of working-class children to thrive was attributed to mothers' fecklessness rather than to the poor economic and social conditions of the time. Mothers were instructed in the art of managing their household resources to promote the health of their children (Oakley 1986). By the Second World War, motherhood had been transformed from a medical to a psychological orientation. The strict disciplining of children became unfashionable, and child psychologists became influential in providing advice on childrearing. Bowlby (1951), on the basis of his work in orphanages, emphasised the need for the child to have a "warm, intimate, and continuous relationship with his mother" (p361); the detrimental effects of maternal deprivation became the single most important post-war theory of child development.

From the 1950's onwards a new development in parenting philosophy became discernible. As well as mothers being constantly available to their children, parents were expected to enjoy their children. Whereas Bowlby had been largely concerned with the prevention of emotional disorders in children, the contemporary emphasis has increasingly been on optimal, as opposed to adequate, levels of achievement in children. Increasing emphasis has been placed on parents as unfoldings of their children's cognitive capacities, with parental ambition directed at having the best developed child (Cunningham 1995). The present study examines contemporary parents' experience of childrearing; their aims, the reality, how they learn the skills and the supports and stresses involved.

1.3 Defining the family

While the family is often thought of as the basic unit of society, it should probably be considered as "a specialised element which serves society in a variety of ways and

depends on society for its stability” (Baggaley 1997 p27). Silva and Smart (1999) suggest that for some, the definition of what a family should be is easily defined as “a heterosexual conjugal unit based on marriage and co-residence (p1).” This ‘ideal’ family is then used as a comparison for other families such as lone-parent households which are then deemed to be some way deficient. However, as Silva and Smart (1999) point out, family structure and function is diversifying in response to social change affecting employment patterns, gender relations and increasing choices in sexual orientations, which are not interpreted in terms of declining morality but as a means of accommodating society. As Baggaley (1997) suggests, society reflects change in families and also effects change upon families over time in a feed-back loop.

Finch and Mason (1993) suggest that while diverse patterns of family life exist, people still feel committed to families, but the concept of family has evolved so that it now refers to the subjective meaning of intimate connections rather than formal, objective blood or marriage ties. Thus family refers to people who sometimes or always live in separate households as well as to people who simply choose to belong together as a family without being legally linked. However, family life is always associated with the sharing of resources, caring, responsibilities and obligations (Finch and Mason 1993), and therefore the function of the family appears to be remaining stable in the face of changing structure. Frude (1990) proposes that a list of an individual’s family members does not represent a family unit, and that the criteria for identifying family involve “feelings of affinity, obligation, intimacy and emotional attachment” (p4); both Frude (1990) and Finch and Mason’s (1993) definitions of family imply that members of an individual’s social network who are not related can also be included as family, as well as allowing for the exclusion of relatives who do not meet his definition of family.

Morgan (1996) develops the concept of ‘family practices’ as a way of expressing his understanding of the de-institutionalisation of the family and the breaking down of the boundaries which have been associated with the private sphere of families and the public sphere of other social institutions. Referring to family practices has

connotations of 'doing' family, with an emphasis on function rather than on structure, and suggests that the family is not in practice separated from other social processes.

1.4 Health visiting practice in relation to working with young families

Despite attempts to widen the remit of the health visiting service to address the needs of the population from the cradle to the grave, the focus of health visiting interventions continues to be young children and their families.

The examination of the processes and outcomes in health visiting has been considered problematic and, some have claimed, impossible. According to Luker (1978), at one time health visitors believed that the results of their work were "too subtle, intangible or elusive to be realistically assessed" (p1257). Intangible and elusive changes can hardly be worthwhile goals or a reason for continuing professional practice, and sit uneasily with the current managerial demands for clinical and cost effectiveness. As Traynor (1993) points out, "it is not enough to be busy on honourable business" (p217).

Two issues are relevant to the discussion of how the processes involved in health visiting should be explored, one relating to the development of research, the other to the history of health visiting. Health service research has been dominated by a medical model, with an emphasis on defined inputs and measurable outcomes, with little interest being shown in the processes involved. This approach suits drug trials and other medical situations. Also, although health visiting has its roots in the 19th century public health movement, the service has been directed by medical officers of health. Thus health visiting practice has been dominated by the medical model, and the 'official' activities of health visiting have been concerned with improving rates of parameters such as breastfeeding, immunisation and clinic attendance for child health surveillance, and examined by measuring outcomes in simple numerical terms.

Cowley (1996a) makes the point that organisationally-led targets such as immunisation rates may seem to health visitors "far removed from the predominant needs of clients, with whom they are in daily contact, and also seem different from

the things for which practitioners *feel* most responsible” (p18). Other studies of health visiting have suggested that health visitors engage in what has been described as “fringe activities” (de la Cuesta 1993) and debate whether these are a way of increasing clients’ compliance with official targets, or are an essential part of health visiting in their own right.

This study uses a qualitative approach and parents’ perspectives to facilitate the examination of the role of health visitors in working with families with young children, in order to contribute to evidence-based practice.

1.5 Involvement of consumers of health care in health service research and development

As early as 1968 the World Health Organisation Consultation Group identified consumer response studies as priority areas in health service practice (Grundy and Reinke 1973). The involvement of consumers and a recognition of the need to obtain their opinions, views and reactions to medical and social service provision has grown in importance in recent years. Locker (1978) suggests that the emphasis on consumer opinion developed at the same time as the sociological interest in inter-personal relations. This interest was strengthened by government sponsorship of studies such as ‘Patients and their Doctors’ (Cartwright 1967), and by a rise in the influence of consumer movements in general.

Earlier changes in the structure of the NHS had begun to establish a role for the consumer in the organisation and delivery of care, and this was legitimated in 1974 by the creation of Community Health Councils, which are charged with the specific task of representing the views of the public to the providers of the service.

Innovations such as the introduction of the Patient’s Charter and the appointment of complaints officers by NHS Trusts, give patients a higher profile in the planning and delivery of health services. In the field of primary care the development of patient participation groups provides an opportunity for the public to influence the running of general practitioner services. In the health visiting service the importance of consumer involvement is evidenced in the change of terms from ‘patients’ to ‘clients’

or 'consumers.' An Investigation into the Principles of Health Visiting (CETHV 1977) stresses the need to involve the recipients of the service in order to explore the health state of an individual or a group. Studies have shown that it is particularly in the field of preventive services that user definitions and perceptions are liable to be most at variance with those of the professionals (Cartwright 1970; Milio 1975; Cartwright and O'Brien 1976).

The present study adopts the ethos of user involvement in examining parenthood and health visiting from the perspectives of users of the health visiting service.

1.6 Aims of the study

The focus of this study is to explore parents' perceptions of the role of the health visiting service in relation to working with families with young children, set in the context of an examination of contemporary parenthood as understood by parents. The aim has been to develop an understanding about the way in which families operate and about the factors which are important to parents in carrying out their role, and to use this understanding of parenthood to explore the relevance of the health visiting service to parents.

The study sets out to gain an insight into the experience of being a parent of a young child, including the positive and negative aspects, the effects of parents' own experience of being parented and the aims and aspirations parents have for their children. The aim is to use this insight to facilitate the interpretation of parents' understanding of the role of the health visiting service, examined in the context of the other influences which impinge on families' lives and other sources of help and support available to them. The different meanings given to the role of the health visitor by clients are examined in relation to other processes operating in parents' lives.

1.7 Overview of the thesis

The thesis begins with a review of the literature pertaining to parenting and health visiting. In Chapter 2, the literature on parenting is considered: a historical

perspective of childhood and parenting provides a background to a review of the literature on parenthood including the role of social support in family life. In Chapter 3 the literature on health visiting is reviewed, with a focus on health visiting practice in relation to working with families with young children. The literature about the process of health visiting, users' views on health visiting and health visiting from a theoretical and historical perspective is examined.

Chapter 4 addresses the study methods, explaining the phenomenological approach used in the study and setting out the aims and the approach used to carry out the study.

The findings are presented in Chapters 5 and 6, focusing respectively on the experience of parenting and of the health visiting service.

In Chapter 7 the conceptual framework provided by Lazarus and Folkman's (1984) theory of stress and coping, Bandura's (1977, 1986) theories of social learning and family nursing are presented and discussed in relation to the study. The rationale for using the three approaches is also outlined. Chapter 8 is devoted to an interpretation of the findings using the conceptual framework. The implications of the findings for health visiting practice, education, policy and research are discussed in the final chapter, taking into account the increasingly high position of parenting on the political agenda.

CHAPTER 2: THE EXPERIENCE OF BEING THE PARENT OF A YOUNG CHILD

2.1 Introduction to the literature review

This chapter begins with a historical perspective of childhood and parenting. Then literature concerned with contemporary parenting is explored, including an appraisal of the literature on motherhood and fatherhood as separate entities. Literature which provides an insight into the role of social support to parents is then examined. The following chapter is devoted to a review of literature relating to health visiting. The literature review commenced by carrying out searches of the electronic databases Medline, BIDS and CINAHL. Others were traced from the references published in papers. The review focuses on literature from 1978-1998, and also includes references to seminal works from the past and to some of the major theorists who have made a significant contribution to the areas of research being reviewed.

Relevant policy documents published prior to data collection are included in the literature review: those produced more recently are reviewed in the discussion chapter. Most of the literature reviewed in relation to parenting comes from the two disciplines most closely related to health visiting: sociology and psychology. Nursing provided most of the material for the review of health visiting literature. The literature relating to parenting comes mainly from the United Kingdom and North America, while that on health visiting originates mainly from the United Kingdom, since health visiting as a universal service is unique to Britain; however, some references to the theoretical basis of health visiting emanate from North America. The literature used to provide a history of childhood and parenting is, inevitably, not research-based. The literature review focuses on parenting in the developed western world.

2.2 The history of childhood and parenting

In a study where the main concern is parenting, it is important to take a historical perspective on families, childhood and the role of parents in order to provide the

background to contemporary issues concerned with bringing up children. Until recently the family was portrayed very traditionally: father the sole breadwinner working regular daytime hours, his wife at home taking care of the house and the children with extended family nearby. Today, however, there are many alternative family compositions and lifestyles: single parent and reorganised families, the increased number of mothers in paid employment, longer and more unsocial working hours and geographic mobility.

Attitudes to children have changed over time. Shorter (1975) claimed that:

“Good mothering is an invention of modernisation. In traditional society, mothers viewed the development and happiness of infants younger than two years with indifference. In modern society, they place the welfare of their small children before all else.” (p170)

Until the end of the nineteenth century infanticide, the sale of children, abandonment and wet-nursing were common, although close and loving relationships between parents and children were the norm (Golden 1990).

In the ancient world children were not seen as important in their own right, but as having the potential of becoming good citizens, and the years of adolescence, from about puberty to twenty-one, were perceived as the key ones in terms of character formation (Dixon 1992). Children were seen in terms of their deficiencies, the adult qualities which they lack.

The advent of Christianity, with its inherent belief in the need of every human being for salvation, immediately elevated the status of young children, and stressed the importance of parental duties (Cunningham 1995).

The mediaeval world recognised *infantia*, the first seven years of life, as a separate stage, during which children should be brought up by their mothers with kindness and a degree of freedom from overbearing adult authority (Shahar 1990). The second stage, *puerita*, up to the age of twelve for girls and fourteen for boys, was the time for education, with fathers having the responsibility for sons and mothers for daughters (Shahar 1992). Whereas in the ancient world, the family included slaves and other non-kin, in the middle ages the family began to assume a structure which

bore similarities to the modern family. By the middle of the nineteenth century childhood was seen as a time which was of vital importance in influencing adult characteristics.

Protestantism was concerned with the concept of original sin, and the need for salvation, which resulted in parents being exhorted to instil discipline and respect in their children (Ozment 1983). In the Catholic church the balance shifted from the family to the Church and its schools as the primary institution for rearing good Christians (Chatellier 1989). Thus religion was a key factor in changing attitudes to children and their upbringing.

During the eighteenth century childhood came to be recognised as a stage to be enjoyed in its own right, rather than only a preparation for something else. Romanticism brought a belief in the idea that life could be seen, not as an ascent to maturity, but as a decline from the freshness of childhood, depicted by poets such as William Blake and William Wordsworth as being the best time of life. Blake (1757-1827) in 'Holy Thursday' depicts children as having "innocent faces clean," while Wordsworth (1770-1850) in "To a Butterfly: I've Watched You Now," refers to "sweet childish days, that were as long as twenty days are now" (Oxford Dictionary of Quotations 1975). Romanticism's reverence of childhood was in complete contrast to the Puritan emphasis on the child as a sinful being.

From 1500-1860 policies were introduced, which shifted responsibility for children's education and welfare from the church to the laity, mainly philanthropists, and which focused more on producing an effective workforce than on religious concerns. Beginning in the 1880's responsibility for the welfare of children moved from philanthropy to the state with professionals becoming increasingly involved (Cunningham 1995).

During the late nineteenth and first half of the twentieth century science began to be used to understand children's development, measure their intelligence and inform approaches to childrearing and to dealing with difficulties in children's behaviour (Cunningham 1995). Freud's emphasis on childhood experiences, especially regarding the handling of children's sexuality by adults (Freud 1927), imbued

parenting with difficulties which could not be resolved by common sense or traditional strategies. Bowlby's (1953) theory of attachment and loss with the emphasis on the mother as sole caregiver during the early years of childhood, and Winnicott's (1965) concept of "good enough" mothering influenced beliefs about how children should be brought up.

Although childcare manuals have been available since the invention of print, during the twentieth century there has been a proliferation of books about bringing up children. In the 1930's Truby King emphasised the importance of the early establishment of regular habits and strict routines for young children in order to promote obedience (Smith 1997). Dr Spock's "The Common Sense Book of Baby and Childcare" has sold 28 million copies since its publication in 1946, making it the best-selling book of the twentieth century after the Bible (Hardyment 1983), and demonstrating the influence of populist writers and parents' quest for information and advice about childcare. More recently, childcare manuals by 'gurus' such as Penelope Leach (1980) and Miriam Stoppard (1995) have been best-sellers, suggesting that parents are looking for expert guidance on how to bring up their children. Childcare manuals have reflected social change by altering their emphasis on the need for rigid routines for children to a more relaxed approach to childrearing.

Children have also acquired more rights. The 1989 United Nations Convention on the Rights of the Child not only provides for the protection of the child but also for the child's right to be heard in any decision that may affect her or his life. Children have the right to bring proceedings against their own parents, an indication that the shift in the balance of power between parents and children extends beyond the economic and emotional spheres. The Children Act (Scotland) 1995 is founded on the principle that all children have the right to be treated as individuals, to be involved in making decisions about matters affecting them and to be protected from all forms of neglect, abuse and exploitation. Thus children have been given many more rights than in the past with a loss of the responsibilities which were previously associated with childhood, such as the need to contribute to the economy of the family. Parents, on the other hand, have had their obligations to children increased,

with a corresponding decrease in their control over children. While childhood has in many ways become associated with increased rights and freedom, other concerns have conspired against this new ideal of childhood. Inequalities in health and social factors, and new factors such as concern about potential dangers from traffic and child abductors have constrained the lives of many children. Parenting has increasingly come into the public arena with a growing awareness of the prevalence of child abuse in families. Social change, with increasing numbers of dual-earner families, reorganisation of families due to divorce and separation, and increasing numbers of families with single-parent and same-sex partners has resulted in an unprecedented diversity of family life.

By tracing the history of childhood and parenthood, and by being reminded that children have not always had the rights and lack of responsibilities that they now enjoy, contemporary family life is brought into perspective. The portrayal of children's needs in terms of nurture and discipline have changed over time. The status of early childhood has also evolved from being considered of little relevance to being seen as a time of critical importance to adult functioning. The historical perspective on childhood demonstrates how family life has evolved in response to social change and suggests that interventions offered to families should reflect these changes in structure and function and in the expectations of agencies involved with them. It also shows how parenting has always been subject to outside influences such as the church and the state.

2.3 The transition to parenthood

Becoming a parent involves an enormous change in lifestyle for most parents. The transition from being an individual to a family usually involves, almost overnight, a dramatic loss of freedom and greatly increased responsibility.

Developmental theorists studying children, adults, and families across the lifespan have focused on what have come to be called *normative* transitions, predictable changes made by virtually every person (e.g., puberty) or by the vast majority in a defined population (e.g., couples becoming parents). Other theorists have been more

interested in individual or family stress and coping in the wake of *non-normative*, often catastrophic events (e.g., war, unemployment, serious illness).

Cowan (1991) describes transitions as long-term processes that result in qualitative reorganisation of both inner and external behaviour. While child developmental psychologists such as Freud and Piaget have concentrated on different stages of childhood, a few theorists (e.g., Erikson 1950; Jung 1964) have considered transitions across the lifespan. Erikson prescribed normative developmental tasks for adults as well as for children. He argues that three psychosocial strengths - hope, fidelity and care - must be achieved to become a healthy, functional person; these strengths correspond to the three major life stages of childhood, adolescence and adulthood (Erikson 1982). Basic trust and hope need to be gained in childhood, and a sense of faith in oneself and fidelity to an identity are required in adolescence. The primary developmental task of adulthood, according to Erikson, is learning to care for others, a process he labelled *generativity*. Generativity, or care, is defined as an interest in establishing and guiding the next generation (Erikson 1982). Erikson believed that nurturing one's offspring was the primary means of achieving this developmental task, although generativity could also be accomplished by contributing in other ways to making the world a better place for the future generation. Despite the acceptance of Erikson's theory of human development, little attention has been paid over the fifty years since Erikson proposed it to the role that nurturing children plays in achieving psychosocial health in adulthood. Lerner and Kreppner (1989) argue that we underestimate and give inadequate attention to the developmental influence of children on their parents; we have been fixated by the influence of parents on their children. Yet a fundamental of developmental theory is that when one part of a dyad develops, the other part develops as well (Bronfenbrenner 1979). Snarey et al. (1987) provide support for the importance of parenting to developing psychosocial health in mid-life. In a study of 343 married men followed up over four decades, it was found that parenting during early adulthood was important for achieving psychosocial generativity.

While the studies discussed so far focus on the effects of life transitions on individuals, family sociologists (Hill and Mattesich 1979), life course theorists (Elder 1978) and some therapists (e.g., Carter and McGoldrick 1988) have attempted to understand transitions made by families who are in the process of formation and reorganisation. Eric Erikson (1950; 1959) claimed that we inevitably experience a period of crisis and intrapsychic conflict when we are faced with new and difficult developmental tasks. Crisis and conflict cause temporary incapacity but they are required for normal developmental growth.

As men and women become parents, they describe marked transformations in the quality of their relationships with their own parents, in their relationship with each other, and in their relationship with their child (Cowan et al. 1991).

The transition from being a couple to becoming a family has been a focus of study and controversy since LeMasters' (1957) apparently surprising proposal that the birth of a first child constituted a 'crisis' for 83% of the 46 couples in his study using quantitative and qualitative methods. The analysis of his intensive retrospective interview data led to LeMasters arguing that this normative transition, typically seen as a time of joy and optimism, could also be a time of significant strain for new parents. Parents seemed unprepared, typified by one mother's comment, "we knew where babies came from, but we didn't know what they were like" (p353).

For the next two decades, other investigators derided LeMaster's conclusions. Many of these researchers were sociologists who asked new parents to complete simple questionnaires (e.g., Hobbs 1965; Hobbs and Wimbish 1977). Their results were interpreted as diminishing the difficulties for parents caused by the birth of a child, and suggesting, as Hobbs and Cole (1976) put it, that "initiating parenthood may be slightly difficult, but not sufficiently difficult to warrant calling it a crisis experience" (p729).

Despite these early conclusions minimising the effects of becoming parents, three separate lines of research continue to suggest that there are significant risks associated with this major normative life transition - for individual men and women and their relationship as a couple. As detailed by Cowan et al. (1991 p79), these are:

- a. Cross-sectional surveys indicate that marital satisfaction declines during the years of child-bearing and child-rearing (Spanier and Lewis 1980).
- b. With very few exceptions, recent short-term studies have shown that couples who had a first child are less satisfied with their marriage than they were in late pregnancy (Lewis 1988).
- c. Epidemiological data on post-partum distress in women, along with several studies of new fathers, indicate that both men and women who have recently become parents are at increased risk for mental health problems (e.g., Golding et al. 1988).

While the birth of children has been blamed for parents' tension and distress in the early years of family life, Cowan and Cowan (1988) have found that parents' ability to adapt to their new role can easily be predicted before the birth, and this proposal is supported by other studies (Belsky et al. 1983; Belsky et al. 1985). Becoming a parent has an impact on the lives of couples, but the pre-baby state of the parents and their marriage contributes much more than the baby does to their post-birth adaptation levels (Cowan and Cowan 1988). The transition to parenthood seems to increase the stress in parents' lives, the differences between the spouses and thereby their level of marital dissatisfaction.

The transition to parenthood is portrayed as problematic but predictable for many parents. This depiction of family life provides a background to the present study and suggests that an examination of contemporary family life provides an important framework for understanding parents' views of the health visiting service within the context of families with young children.

2.4 The meaning of parenthood to parents

Having children appears to be a very ordinary aspect of life and the reasons why couples decide to embark on parenthood have been the subject of little research. Until the advent of reliable contraception parenthood was unavoidable for married or co-habiting couples, and so the question was superfluous. Until recently it was assumed that all couples would become families, and failure to do so resulted in sympathy for those who were unable to have children, and some degree of contempt

for the very few who chose to remain childless. While there is interest in the increasing number of couples who are choosing not to have children, there is little research available on the significance which children bring to their parents. However, Gerson (1985) in her grounded theory analysis of interviews with 63 women which set out to explain how women link decisions about work and family, found that those who were reluctant to embark on motherhood were nevertheless influenced by what they saw as the costs of childlessness: decreased social approval, the loss of a major life experience with intrinsic value beyond its social measure and the prospect of a lonely old age. Those who embark on parenthood without pondering the alternative appear to be of little research interest.

Psychologists appear to agree that meaningfulness derives from an individual's sense of pursuing important aims or fulfilling a purpose to which the individual is committed. Klinger (1977) states that "meaningfulness seems to arise out of people's relationship with their incentives" (p10), when they can pursue and enjoy important, valued incentives, their lives feel meaningful; when they are deprived of important, valued incentives, their lives feel less meaningful.

Busfield and Paddon (1974) state that the meaning and significance that children are believed to bestow on people's lives is a central theme in their desire to have children. Blake (1979) too found that for a high proportion of her respondents children were seen as having "social investment value," that is value "for providing meaning in life, for giving women a status without which they would be unfulfilled and for cementing marriages" (p251). Blood and Wolfe (1960), state that "children give life purpose through providing something to work for, plan for, look forward to" (p139).

Boulton (1983) found in her study (see section 2.5 p21), that children were an important incentive in which parents were emotionally involved and to which they were deeply committed. Their children therefore gave them a sense of purpose and in pursuing this purpose, they experienced their lives as meaningful. Women said that their children's dependence on them, and their children's need for them as unique individuals, made parenthood especially meaningful.

A study of families and the way they function therefore needs to address the deeper and more abstract aspects as well as the everyday experience of parents. Parents today, because of improved contraception, have much more choice than previously about whether and when to have children. Women also have many more opportunities for finding fulfilment in other ways, especially in paid employment, and so the decision to have children is perhaps more complex than in previous generations. As parenthood becomes a more optional part of people's lifecourse and the roles and expectations of women change, it is timely to look at parenthood within these contexts. In relation to the present study, it is important to be aware that for many parents even the decision to embark on a planned pregnancy may have been difficult to make.

2.5 Motherhood

According to the theories of maternal role attainment based on the work of Reva Rubin, a woman defines her role as a mother according to her interaction with her child and responds according to her situational context, the way she perceives her past and present and her values. Three interdependent categories of the self-system in maternal role-taking are ideal image, self-image and body-image (Rubin 1967). Ideal image represents the qualities, traits, attitudes and achievements that a woman sees as desirable for maternal behaviour. Self-image represents a consistent 'myself' that depicts the continuation of self into the present context, but with little sense of a historical self. Body image, the way in which a woman perceives her body and its capacity to function and accommodate, is especially relevant to maternal role-taking during pregnancy and early post-partum.

Rubin (1984) carried out a study of more than 6,000 women who were observed and listened to by nurses giving nursing care during pregnancy and the first six weeks post-partum. Rubin (1984) defines maternal role attainment as a process in which the mother becomes competent in her role and incorporates her behaviour as a mother with her other role sets, so that she feels at ease with her identity as a mother. Mothering behaviours reflect social norms, which are common beliefs about what mothers should and should not do. These are learned indirectly as the woman is

mothered as a child, and more directly during an anticipatory phase of role attainment during pregnancy, when the woman seeks out role models. Rubin's understanding of maternal role attainment raises questions about what constitutes common beliefs about how today's mothers should behave in a time of rapid social change, when many women have work and other pressures competing with their mothering role, and when women's own upbringing is unlikely to be of relevance to them in their search for suitable approaches to copy when raising their own children. The present study therefore explores how contemporary women adapt to their new role as mothers.

Numerous studies suggest that motherhood is problematic for women. In a quantitative study of 252 primiparous women, looking at the process of maternal role attainment over the first year of a child's life, Mercer (1985) found that 64% of mothers stated that they had internalised the maternal role by four months, while 4% had failed to internalise the maternal role by one year, raising the question of whether all mothers ever do. However, the study does not elucidate the factors which enhance or diminish the process such as bonding between the mother and child, the enthusiasm or reluctance of the mother to embark on parenthood and the support being provided by the father and others.

Barclay et al. (1996), conducted a grounded theory analysis of the experience of 55 first-time mothers in which the aim was to understand the processes by which 'normal' mothers take on their maternal role. They found that becoming a mother involves six concepts: realising, unready, drained, aloneness, loss and working it out. Barclay et al. (1996) suggest that:

"Whilst the act of giving birth determines motherhood in the biological sense, in the emotional and personal sense 'becoming a mother' takes some time. 'Realising' the impact of the child on their lives comes as a shock to mothers. The magnitude of the change they experience and the need to resolve the birth make it difficult. Women feel 'unready' and are not prepared for the experience of 'becoming a mother.'" (p725)

They feel alone and frequently unsupported by partners, health workers and society as they work out how to become mothers. Women feel drained by physical and

emotional fatigue, lack of sleep and the demands of the baby. The experience of new motherhood involves losses which are accompanied by grieving and sometimes resentment. Gains attached to being a mother may take months to be evident but usually compensate women for the losses they experience. Eventually women are able to 'tune in' to their babies as they work out how to 'become mothers' (Barclay et al. 1996).

Three factors mediate women's experience of new motherhood: the nature of the baby and the baby's reactions to the mother's behaviour, prior experience with other people's babies and the nature of social support available to women (Barclay et al. 1997). In relation to the current study, these factors are likely to affect mothers' requirements in terms of health visiting interventions.

Numerous studies of motherhood from the point of view of women demonstrate that the attainment of motherhood appears almost uniformly problematic for women (Oakley 1980; Richards 1985; Crouch and Manderson 1993). The work of Oakley has been particularly significant. She describes a woman's response to childbirth, particularly first childbirth, as akin to the response to other major life events. Women tell of enormous disruptions to lifestyles, routines, and identities (Oakley 1980). The women in Oakley's study of 60 mothers of first babies talked about feeling anxious and depressed, and found little satisfaction in their new role. The strain of meeting everybody's demands left women feeling exhausted and frustrated. Women spoke of loss, and in particular, loss of identity. Oakley concludes that easy adaptation to first-time motherhood is unusual. Crouch and Manderson (1993) interviewed 93 Australian women once or twice during pregnancy and up to four times during the first six months after birth. Women in Crouch and Manderson's (1993) study spoke of feeling overcome, as though they were not living in the real world, and were distressed when they realised the impact the baby was having on their lives. Richards' (1985) study of sixty Australian married couples with young children also highlights mothers' feelings of loneliness and loss of self-identity.

Barclay et al. (1997) propose that mothers "undergo a profound reconstruction of self" (p727). This finding supports Rubin's (1984) contention that "from the outset of

labour to the destination, childbearing requires an exchange of a known self in a known world to an unknown self in an unknown world" (p52).

Rogan et al. (1997) writing about the same study as Barclay et al. (1997), propose a theory of early motherhood, and the ways in which mothers move from an initial phase, often described as "this isn't my life any more," to a state identified by women as being "in a certain tune" with the baby. Feeling overwhelmed and uncertain of their identity makes women feel physically and emotionally exhausted, resulting in them being less able to interact with others, seek assistance, have time out for themselves or resume further interests, so that they feel alone and mourn the loss of their previous life. In this context women take on the challenges of motherhood and start working out how to care for their baby and to make the changes required to incorporate their baby into their life. Gradually women overcome the difficulty and distress and become organised, slowly gaining confidence in their ability to care for their baby and feeling positive about their interactions with their baby. This phase is characterised by developing a sense of synchrony with the baby and a sense of self as a mother.

Boulton (1983) conducted a qualitative study of 50 mothers of young children, of whom 25 were middle-class and 25 were working class. Half the respondents did not enjoy the day-to-day aspects of childcare (44% of working class and 60% of middle class respondents). However, on reflection, two thirds of the middle class mothers and half the working class mothers talked about the sense of meaning and purpose they found in motherhood. Working class women tended to find their children a source of companionship, and enjoyed playing with them, whereas middle class mothers found young children boring company and played with them out of a sense of duty. Mothers reported feeling overwhelmed and out of control, because generally they were solely responsible for their children and were responsible all the time. Children interfered with other essential activities, such as housework, and limited leisure activities to those which took place in a child-centred world (Boulton 1983).

Mothers said that they had a sense of monopolisation and loss of identity. Children were always present physically, and always had to have their needs met first.

Mothers often coped by seeing this stage as a short-term episode, although some were upset that they were not enjoying it. Boulton (1983) describes one mother as being "frustrated and unhappy with the fact that she was frustrated and unhappy looking after her children" (p106). However, they also felt valued and significant to their children and this helped to ameliorate the feelings of responsibility they had. For many mothers bringing up children was rewarding rather than enjoyable. Children were a source of hopes, dreams and ambitions to mothers; mothers aspired to better things for their children, in relation to what they had missed as children, to their present situation and also in relation to ambitions they had failed to realise. Boulton's (1983) study suggests that the stresses of motherhood persist beyond the early days and that it is relevant to look at the parents' experience of their role beyond this initial stage.

Being the mother of a young child is portrayed as being complex and demanding. The early days appear to involve many losses as well as gains, with negative emotions very prevalent during this time. Gradually mothers achieve some harmony and adapt to their new role through establishing a new sense of identity as a mother and by building up a relationship with their child. Previous research on motherhood suggests that the interpretation of mothers' experience of their role provides an important background to a study of parents' perceptions of the role of the health visiting service with families with young children. The literature search revealed that most research on motherhood concentrated on the transition to the role and that there was little recent research about day to day life with young children. The current study's exploration of the experience of parents of children at the toddler stage is therefore timely.

2.6 Mothers and employment

One major social change which has impacted on family life in recent years has been the increase in the number of dual-earner families, with the employment rate of mothers with children aged under five years having risen from 22% in 1981 to 46% in 1994 (Harrop and Moss 1995). It is therefore important to understand how contemporary mothers' employment status - full-time, part-time or not in paid

employment - affects family life. From a historical perspective, in pre-industrial times women were able to combine work and childcare while the industrial revolution meant that young children had to be cared for at home by non-working mothers. After the end of the second world war, there was an ideology of the traditional family with the father as sole bread-winner, and the mother at home looking after the house and children.

While the number of dual earner families has increased, changes in ideology may have lagged behind. Mothers of young children who work are usually discussed in comparison with the accepted work ethic of fathers, and there is an implication that mothers have a degree of choice in relation to paid employment; this is mirrored by references to fatherhood, which is generally examined in comparison to motherhood, as outlined later in this chapter.

Family life may be changing in significant ways, but in the face of change, ideologies of family life are notable for their emphasis on stability and continuity (Morgan 1985). Brannen and Moss (1991) suggest that dominant ideologies about motherhood emphasise women's primary responsibility for children and remain highly ambivalent about women with young children having full-time jobs. In contrast, ideologies of fatherhood continue to emphasise the importance of male breadwinning, and therefore employment. Borchost (1990) uses the term "political motherhood" to conceptualise the ways in which government policy on child care influences parents' options. In practical terms, government policy influences "the responsibility that mothers have for small children very directly" (p160). Ideologically, the extent to which child care is provided by the state may be interpreted as an indication of implicit and explicit messages about the duties of motherhood (Brannen and Moss 1991). Lewis (1992) describes Britain as a "strong male breadwinner state" in which a clear dividing line is drawn between public and private responsibility. There is little statutory provision in relation to flexible working hours, child care provision and parental leave, in comparison with 'woman-friendly' Scandinavia or with France, which Lewis labels a "modified male

breadwinner state,” with work policies which go some way to help families with young children.

Brannen and Moss (1991) followed 255 women, 75% of whom intended to return to work after the birth of their first child, the remaining 25% intending to give up paid employment. They found that the demands of managing the dual earner lifestyle fell mainly on mothers. There was a tendency for mothers to take part-time employment, often at reduced pay and status. Sometimes this involved within-occupation downward mobility, for example teachers in promoted posts opting for supply teaching, and sometimes involved women in fairly high status jobs taking relatively menial jobs locally to reduce travelling time. Fathers’ incomes were seen as more important and permanent than those of mothers, as women considered the possibility that they might give up work in the future if they felt that their child needed full-time mothering, or if they had a second child. There was a culture of impermanence surrounding the symbolic significance of women’s earnings to the household, with women playing down the importance of its actual significance. Since it is ten years since this study was carried out, it is timely to examine the relative importance of fathers’ and mothers’ incomes from the point of view of contemporary parents.

There is debate about the degree to which the introduction of family-friendly government policies will eventually alter the private and qualitative aspects of parenthood. Gershuny et al. (1994) propose an optimistic view that changes will take place, especially in terms of the role of fathers, but that this involves “lagged adaptation,” through an extended process of household negotiation extending over many years and perhaps generations, rather than a short-term redistribution of responsibilities. However, Calasanti and Bailey (1994) propose that “changes in society at large do not necessarily presage changes in the household: family relationships have their own dynamic and relative autonomy” (p39). The structure and function of the family in the future therefore seems uncertain.

The literature on mothers of young children and employment is concerned mainly with the effects of women’s employment: firstly on children’s health and

development, and how these factors are affected by children being cared for by 'mother-substitutes,' and secondly on women's health and self-esteem.

The psychology of child development has been the main approach used to examine the effect of maternal employment on children's health and welfare. As a consequence of attachment theory - the notion that the emotional development of the child depends mainly on a relationship with one person, the mother - it has been assumed that children require stable, full-time mothering in order to develop satisfactorily (Bowlby 1951, 1958; Ainsworth 1962). Shared childrearing is discussed in the context of maladjustment - typically where daycare leads to insecure attachment in children (McCartney and Phillips 1988). There has been a presumption that the employment of the mother is disruptive to the family and damaging to the child (Bronfenbrenner and Crouter 1982). Even though a great deal of research has found that maternal employment *per se* does not adversely affect children (Hoffman 1989), the idea that maternal employment is damaging to family life has persisted. This belief is due to normative assumptions concerning the conduct of family relations (Hoffman 1987). Although the portrayal of motherhood has changed over time (McCartney and Phillips 1988), maternal employment has generally been viewed negatively except in wartime. Brannen and Moss (1991) suggest that since responsibility for children and childcare is automatically ascribed to mothers due to the fact that it is women not men who give birth, the issue continues to be discussed in terms of whether and to what extent children suffer from lack of full-time mothering, rather than the extent to which children (and their mothers) thrive when the care of children is shared with others. A more liberal approach is to examine the conditions under which mothers may take employment without unduly affecting the carrying out of their main responsibilities associated with childcare, the typical solution being to work part-time (Hoffman 1987). While some studies have been concerned simply to explore whether mothers' employment *per se* damages children, other studies have examined other factors and have paid "increased attention to the intervening processes rather than the simple examination of child outcomes" (Hoffman 1989 p284). One factor which has been presumed to be important in linking employment, mothering effects and child outcomes is the degree to which

employment provides mothers with a sense of fulfilment and well-being (Kessler and McCrae 1981).

The relationship between employment and well-being among women has been explained in two ways (Arber et al. 1985). In the first, paid employment has a positive effect, buffering women against certain negative aspects of being full-time housewives and mothers, such as isolation and the tedium of housework and childcare; it may also increase women's sense of independence and self-identity. Alternatively, employment has a deleterious effect because of the increased demands it presents to women. The several roles of women - housewife, mother and paid employee - may lead to role strain because of fatigue and role overload, role conflict and result in psychological stress (Lewis and Cooper 1988). In exploring contemporary parenthood, it is therefore important to examine parents' understanding of the effects of different facets of women's lives on their well-being.

Olson, Ardis and DiBrigida (1994), in a survey of 233 mothers of toddlers, looked at the relationship between maternal depression, employment status and satisfaction with work role. Depressive symptoms were similar when employment status alone was considered (working full-time, working part-time and not in paid employment). However, 67% of mothers who were dissatisfied with their current work role had depressive symptoms compared to 35% of those who were satisfied. Independent of work role satisfaction, mothers employed part-time were less likely to be depressed than mothers who were not employed or were employed full-time. It is suggested that part-time employment's association with less depressive symptoms may be because of experiencing the rewards of employment without role overload. The study does not elucidate the aspects of work and family life which affected women's responses.

Gerson (1985) found that when women found their work experience pleasant and nurturing, staying at home felt like a demotion, "a step backwards from the adult world" (p78). Motherhood threatened to impose not only isolation, but also, and perhaps worse, personal denigration. Both Gerson (1985) and Brannen and Moss (1991) found that when women's hopes for personal fulfilment did not materialise with the birth of a child, they often started making career plans for their future.

Gerson (1985) found that women who had been reluctant to have children tended to work part-time, reducing their burden of childcare by having fewer children, by negotiating childcare responsibilities with their partners before pregnancy and by changing their beliefs about the needs of children; they justified their decision to return to work by reasoning that paid employment made them happier, which was important for their children, but they were not exhausted by the demands of full-time work.

The literature on mothers and employment suggests that deeply entrenched attitudes to childrearing persist even in a period of rapid social change, and that working outside the home can impose stresses additional to those attributable to caring for children on women. However, employment appears to be important to many mothers, and the literature suggests that part-time employment may be beneficial to mothers by providing social support, relief from boredom and increased self-esteem compared with full-time motherhood, while not being associated with the fatigue which appears to accompany full-time employment. In terms of the current study, it is therefore important to look at the effect of mothers' employment status on the experience of parenthood for both mothers and fathers.

2.7 Fatherhood

The literature on the experience of parenthood has been reviewed, followed by an examination of the literature relating particularly to motherhood and to mothers and employment. Now the literature pertaining to fatherhood is considered.

Historical accounts of fatherhood tend to reveal a stereotype based on traditional views. Information about fathers has often been gathered from mothers. As pointed out by Moss (1995) mothers are usually far more accessible to researchers than fathers and there is no doubt that female dominance of child care is an accepted norm in our society, although the situation is changing with the increase in the number of dual-earner households. The literature review revealed that the father's role is usually discussed by mothers, fathers and researchers in relation to that of the mother; similarities and differences are proposed, but always with the sometimes

unacknowledged assumption that mothers generally, although not necessarily in specific families, are the main carers. Therefore while many of the findings of the review of the literature on motherhood apply to both parents, the literature on fatherhood concentrates on making comparisons with the mother's role. This approach mirrors the literature on mothers and employment, where paid employment is discussed as a slight deviance from the norm, even though this is no longer the case.

Early literature accords little importance to fathers, who are seen as superfluous or even a hindrance to mothers and in some cases downright hazardous to their children. Pre-1950's there is little or no mention by child-care experts of a father's role within the province of childcare. Truby-King, whose views were highly regarded in the 1930's and 1940's, makes no mention of fathers at all (Smith 1997). In the 1950's it was being acknowledged that fathers were taking on some of the care tasks of their infants. Hostler (1953) describes the father as "the first intruder into the magic circle of mother and child." A decade later, Illingworth and Illingworth (1964) depicted fathers as being able to deputise for mothers in an emergency, but with the assumption that they were just 'holding the fort' in the mother's absence. Newson and Newson (1963), in their survey of 100 families of young children in the east end of London, found that bathing babies was the task least likely to be undertaken by a father - the reason for this was the fear of dropping, hurting or even drowning the baby on the part of both mothers and fathers.

In the 1970's and 80's, a new element in attitudes to fatherhood emerged. Academic studies started to take place asking fathers directly about their feelings and involvement with their infants. Backett (1982), in her study of 22 middle-class families in the early 1970's, with all the mothers having given up paid employment, found that couples went to some length to sustain a belief in the active involvement of the father, even though this was often not carried out in practice. In reality, mothers had overall responsibility for children with fathers assuming an optional helping role. The current study examines the extent to which this situation had changed in the two decades since Backett's (1982) research was carried out. At the

same time films such as *Kramer v Kramer* began to show men as loving parents and relatively competent housekeepers (La Rossa 1988). These images provided parents with new models for parent-child relationships, though some scholars argued that the new images were more a reflection of changes in ideology than of social trends (La Rossa 1988). Furstenberg (1988) calls attention to the disparity between images of 'good dads' - those increasingly involved with their kids - and 'bad dads' - those who are physically, emotionally and financially absent from their families.

Despite evidence of fathers being more involved in the care of their children than they were in the past, men's long working hours can reduce the amount of time they can spend with their children. According to Brannen et al. (1995), first-time sole-earner fathers work on average 55 hours a week during the first three years of fatherhood. Alongside increasing hours of work, the structure of employment has been changing. Ferri and Smith (1996) carried out a survey of almost 6,000 families in which the parents were married, as part of the 1991 National Child Development Study, which followed up everyone born during one specific week in 1958. They found that two-thirds of the fathers surveyed in 1991 were working in the evening and six in ten at weekends. Ferri and Smith (1996) found that there was a marked reduction in family activities where fathers worked more than 50 hours and an increase for those working less than 40 hours. The long hours worked by many fathers provides one explanation for their lesser involvement in childcare compared with mothers.

Ferri and Smith (1996) found that fathers become more involved in the care of their children as mothers' participation in the labour market increases and both mothers and fathers report care to be more likely to be shared between them. None the less, even in families with the most egalitarian child-care arrangements - those in which both parents work full-time - a quarter of the fathers reported that mothers were still mainly responsible for child care, while a third of mothers reported mostly being responsible for it.

When mothers work part-time they are more likely than full-time working mothers to take the main responsibility for their children, and a smaller proportion of husbands

and wives report that they share looking after the children between them (Ferri and Smith 1996). Mothers retain overall responsibility for children regardless of the increasing involvement of fathers (Brannen et al. 1995; Lamb 1995). The findings of the above studies suggest that, as women become increasingly involved in paid employment, fathers undertake more childcare duties, but the overall responsibility remains with mothers.

A number of studies have looked at the division of parental responsibility for particular aspects of child care, such as the teaching of good behaviour or discipline and the care of sick children (Martin and Roberts 1984; Kiernan 1992; Ferri and Smith 1996). More than eight out of ten cohort fathers and cohort mothers in the 1991 National Child Development Study, reported sharing equally the “teaching of good behaviour” (Ferri and Smith 1996). By contrast, caring for sick children is less likely to be shared equally, and falls to mothers rather than fathers (Witherspoon 1988; Kiernan 1992; Ferri and Smith 1996). Where fathers are involved in the care of their children, studies repeatedly report that it is with the more pleasurable and leisure aspects of child care; the ‘rough and tumble’ play between fathers and children in early childhood and sports activities as they get older (Brannen et al. 1995; National Opinion Poll 1995). Recent studies generally support the conclusion of earlier reviews that fathers are more involved with sons than with daughters (Harris and Morgan 1991; Aldous et al. 1998). The studies which highlight the unequal division of childcare between parents do not explore whether parents are in fact happy with this arrangement, or whether these inequalities are instigated by mothers themselves. It therefore cannot be assumed that equal sharing of all childcare is the best arrangement for the majority of families.

Hochschild (1989), in her grounded theory study about women and work, involving 63 families, suggests that a woman’s gender ideology determines how much power she wants to have in a relationship: less, more or the same amount as her partner. Hochschild describes three types of ideology: traditional, transitional and egalitarian. Even though she works, the traditional woman wants to identify herself with her activities at home (as a wife and mother), wants her husband to base his identity at

work and wants less power than him. The traditional man wants the same. The egalitarian woman wants to identify with the same spheres as her husband does and to have an equal amount of power in the marriage. Between the traditional and egalitarian is the transitional, who wants to identify both with home and work but wants her husband to focus on earning a living. A typical transitional man is quite agreeable to his wife working, but expects her to take the main responsibility at home too. Hochschild (1989) found that women's ideologies were changing faster than those of men, with women differing from their own mothers more than their partners differed from their own fathers. Many men who were taking an active part in childrearing resented the lack of contact they had had with their own fathers and were anxious not to repeat this with their own children. The findings from this study suggest that families function in different ways and that harmony about roles between parents is more important than trying to define the ideal division of childcare. It is therefore important to examine not only the extent to which childcare is shared by parents, but also parents' views about how this affects the functioning of the family.

Concentrating on fairness in studies of family work results in insufficient attention being paid to the developmental tasks that adult men and women face while building a life together (Marsiglio 1995). Although parents often intend to adopt an egalitarian approach to childcare, when the baby arrives there is a distinct traditionalisation of family role behaviour; mothers take on a greater proportion of daily family work, and fathers redirect time and energy to occupational pursuits (Cowan and Cowan 1992). From an Eriksonian perspective, fathers' underinvolvement in caregiving during the early parenting years puts men at a disadvantage for achieving generativity (Erikson 1982), described earlier in relation to family transitions (see Chapter 2:3 p14). Thus it appears likely some men's lack of involvement with their children may result in their own psychosocial development being impeded as well as in any negative effects suffered by their children.

Fatherhood often presents men with experiences for which their past lives provide little preparation. The result is a developmental disequilibrium; fathers often feel

“mixed up” (Lewis 1986 p151) or “scared” (Greene 1984 p7), because they sense that one stage of their lives, a more egocentric and instrumental one, is coming to an end and they are unprepared for the next stage. This is similar to the sentiments felt by women during the transition to motherhood, as discussed earlier in this chapter (see section 2.5).

However involvement in childcare is more optional for fathers and is limited by factors such as breastfeeding and women’s tendency to take overall responsibility for children (Cowan and Cowan 1992). Moreover, for many men, working hard to provide for their families is the primary way they express interest in their children’s lives (Doherty 1991). Even when men become more involved with their children at a later stage, their transition may lag behind that of women. Hawkins et al. (1993) elaborate on the ways in which the transition to parenthood is easier for women than for men. Women become attuned to their new role because of their experience of pregnancy and the immediate demands of a new baby which they must meet. From infancy, girls are socialised for caregiving; fathers are socialised for providing. In addition, once the baby arrives, mothers often have numerous social supports to help them adjust to their roles, whereas society provides few supports for fathers. The biological and social forces that accelerate mothers through the difficult transitions to parenthood therefore appear to be weaker for men. Men must therefore make a more concerted, conscious effort to shift both their inner psychological worlds and external behaviour to be involved in daily family work. These findings may contribute to explaining why fathers are generally less involved with childcare than mothers, even when an equal division might be expected, such as when both parents are working full-time. Aldous et al. (1998), in a quantitative study of the parents of 762 young children over a five period, found that fathers’ involvement with older children correlated positively with their involvement in the early stages. This suggests that the early days of fatherhood are critical for establishing the position of fathers within their newly created families. The current study therefore looks at parents’ reflections on the early days of family life and the effect of this period on their present family dynamics.

While the effects of mothers' paid employment on mothers has already been discussed (section 2.6) the results of this social change on fathers is now examined. Hood (1986) proposes that this trend has minimised the 'good provider' role of fathers, resulting in men's performance as fathers being assessed in relation to participation in child care rather than earnings, and has made contemporary marriage increasingly optional. The outcomes of increased participation by fathers in daily family life is a more equal balance of power between parents, with fathers developing sensitivities that have been assumed to come with being a mother (Hochschild 1989). In addition, children with involved fathers thrive intellectually and emotionally, and develop more balanced gender stereotypes and expectations (Biller 1993). Sharing domestic labour is also associated with less discrimination against women and more gender equality in society at large (Chafetz 1990).

Additional social, demographic and life course factors have also been found to be associated with the sharing of family work. Parents who delay the transition to parenthood until their late twenties and thirties also tend to share more family work (Coltrane and Ishii-Kuntz 1992). Individuals who have divorced and remarried, especially those giving birth to a child in a second marriage, are also especially likely to share family work (Demo and Acock 1993). Those parents who have fewer, older or male children appear to share more than others (Ishii-Kuntz and Coltrane 1992). In an age of increasing geographical mobility and reorganised families, and the tendency to delay childbearing till later than previously, it appears likely that fathers' participation in childcare will increase.

Young fathers may still be developmentally immature and may be confronted with parental responsibilities before they have the cognitive and emotional maturity to handle them effectively. They may have unrealistically high expectations of their children's abilities because they are unfamiliar with the stages of child development (Pirog-Good 1993). However, most studies of young parents still focus exclusively on mothers (Lamb and Elster 1990). Adolescent boys are often confused as they confront their newfound sexual maturity and struggle to form their own adult male identity, prompting them to cling to traditional masculine gender roles by

aggressively distancing themselves from what they see as feminine activities (Teti and Lamb 1986). The problems encountered by adolescent fathers are significant in the context of the increase in numbers of teenage parents.

The literature review suggests that paternal roles are changing, but that traditional ideologies persist for both mothers and fathers. This is not surprising since the most influential role models, parents' own parents, were mostly traditional in their division of responsibility with respect to childcare. It is therefore to be expected that in a period of very rapid change, mainly in the role of women, the shift in practice might be slower than the reshaping of the ideology of parenthood. However, the constant finding that mothers appear to be more involved than fathers in caring for children suggests that complete sharing of childcare by parents is not likely to be common for a long time in the future. It is therefore relevant to include an examination of parents' views about the role fathers play in their family life within an exploration of contemporary fatherhood.

2.8 Parents' approach to discipline

Bringing up children involves teaching them moral responsibilities. It is widely regarded that an important role of parents is the promotion of behaviour in their children which is acceptable to others, and which reflects well on the child and the parents. The ways in which the portrayal of children and their needs have changed over time have already been outlined (section 2.2). Approaches to discipline have mirrored these changes in the understanding of children and their needs, whether purging them of sin or allowing them a carefree existence. The development of child psychology has also influenced approaches to discipline, and the increasing emphasis on the rights of the child, embodied in the Children (Scotland) Act 1995 brings the use of physical punishment into the political arena for the first time.

Backett (1982) in her study of 22 middle-class families, (described in section 2.7 p28) found that parents felt a responsibility to produce children who could fit into society. Two aspects of discipline were described. Firstly, parents saw themselves as having a duty to teach children ideas about 'right and wrong,' and to enforce these

ideas by means of varying punishments. Secondly, parents wanted to encourage children to develop self-discipline by fostering the growth of a certain rational and reflective awareness of self and others.

Howard (1996) describes discipline as:

“systems of teaching, learning and nurturing that are used in childrearing. These systems include procedures that encourage appropriate behaviour and deter misbehaviour according to the child’s developmental abilities. The system’s ultimate goals are for the child to achieve competence, self-control and self-direction.” (p809)

Howard (1996) points out that many of the same parental factors which interfere with establishing optimal discipline are the ones which make it more likely that the child will have problematic behaviours. These include: lack of social support, social disadvantage, low educational level, and mental health problems.

Approaches to discipline have to be appropriate to children’s cognitive development (Committee on Psychosocial Aspects of Child and Family Health, 1997-1998, American Academy of Pediatrics 1998). The earliest discipline strategy is passive and involves the establishment of generally structured daily routines. As babies become more mobile, parents must impose limitations and structure to create safe spaces for them to explore and play.

According to Piaget, most children between the ages of 2 and 6 years are in the preoperational stage of development. Preoperational thought tends to be egocentric, to focus on one salient element of an event - ignoring other important elements - and to be characterised by concrete images of reality (Baldwin 1955). Thus, as succinctly expressed by Blum et al. (1995), “children in the preoperational stage of cognitive development have a limited ability to distinguish between their own points of view and those of others” (p339). They also have difficulty distinguishing causation from coincidence and fantasy from reality (Campbell 1990). These two features of the pre-operational stage compound to produce challenging behaviours in young children which most parents find difficult to manage.

Blum et al. (1995) reviewed studies that explicitly investigate the ability of adults' verbal explanations or instructions to alter the behaviour of young children. Overall, although reasoning and verbal explanations seem to have clear benefits for children older than six years, the beneficial effects are less clear for children younger than six years, and in some cases caused a deterioration of behaviour. Blum et al. (1995) propose that verbal reasoning may represent abstractions that are difficult for toddlers and pre-school age children to understand. Even children who can verbalise the explanations may not demonstrate any change in behaviour, and the parent may inadvertently be reinforcing the behaviour they wish to stop.

Time-out and removal of privileges are approaches to discipline that involve removing positive reinforcement for unacceptable behaviour. For young children, time-out generally involves removing parental attention and praise or being placed in a room or a chair with no adult interaction. In pre-school children, time-out has been shown to increase compliance with parental expectations from 25% to 80% (Scarboro and Forehand 1975). Findings from these studies suggest that parents would benefit from being aware of the relative effectiveness of different strategies and that physical punishment could be replaced in many cases by the use of time-out. It is therefore relevant to explore parents' experience of managing their children's behaviour and their knowledge and use of, and attitudes to, both physical punishment and other approaches to discipline.

Parents' approach to disciplining their children is affected by their own experience of being parented. Numerous studies have provided evidence of a link between parents having been abused as children and subsequent use of harsh discipline with their own children (Straus 1983; Egeland et al. 1987). Simons et al. (1991) attempted to identify the mechanisms whereby harsh disciplinary practices are transmitted across generations. They found that exposure to harsh parenting during childhood had both a direct effect upon the harsh parenting of fathers and mothers (interpreted as a modelling effect), and an indirect effect through its impact upon personality and discipline beliefs. There is little literature relating to the transmission of attitudes to physical punishment in families not identified as abusive. However, Simons et al.

(1993) looked at the transmission of supportive parenting in addition to harsh discipline. Quantitative measures were used with 451 families, each of which had a child in seventh grade (last year of primary school) and another child within four years of this age. Parental satisfaction with the child's behaviour was related to quality of parenting received as children. Those who had experienced involved, supportive parenting when they were young reported high satisfaction. Simons et al. (1993) suggest that parents who are involved and nurturing convey the idea that parenting is a pleasant, gratifying endeavour, and this message increases the probability that their children will grow up to experience interaction with their offspring as rewarding. Parents' perceptions of how their own childhood experience of being disciplined affect their approach to disciplining their own children is therefore also examined in the present study.

Graziano (1994) describes smacking as a form of subabusive violence that does not give rise to the common definitions of abuse. He suggests that most parents accept smacking as a proper act of discipline in the children's best interests. Studies indicate that some 90% of parents use corporal punishment in childrearing (Straus 1994; Graziano and Namaste 1990). Graziano et al.(1996) carried out a survey of 320 middle class, white, non-abusive, intact, well-educated, two-parent families with an average of 2.6 children. The ages of the children are not described, although as the children were involved in providing information it is assumed that they were all older than the children of the parents who participated in the present study. They found that corporal punishment was used in 83% of the families, although only infrequently in most families (less than a few times a month) and at only moderate levels of intensity. About 35% of children reported that they were sometimes smacked with an object such as a stick. The behaviours which most readily elicited physical punishment were those in which the parents perceived that the child was, in some manner, actively non-compliant, disobedient or was disrespectfully challenging parental authority. These middle-class parents not only used corporal punishment but also justified it, with 93% believing it to be a useful and effective approach, teaching children important lessons. However, it was seen as being effective in the short-term but not in the long-term, and 85% of the parents would have rather not used physical

punishment at all, and would have used alternative means if any good alternatives were available. Most of the children in the families reported that physical punishment made them feel upset, angry and hurt, but they accepted it as a parental right. This acceptance of physical punishment might be expected to result in the same children not questioning their attitude to smacking when they become parents themselves. The study raises questions about whether the common use of physical punishment by parents makes it acceptable to them.

Socolar and Stein (1995) undertook a cross-sectional survey of 200 mothers of young children aged between one and four years to describe maternal beliefs and practices of spanking toddlers. It was found that two year olds were smacked the most, significantly more than one year olds but not significantly more than three year olds. Belief in spanking was stronger for dangerous misbehaviours, for older children, by mothers of a lower socio-economic background and by mothers who had been smacked as a child. The present study uses a qualitative approach to explore parents' perceptions of the factors which affect the management of their children's behaviour.

Parents' use of corporal punishment has spawned much debate among family researchers and practitioners (McCormick 1992; Straus 1995). It has been shown that toddlers and younger children are more likely to be smacked than older children (Giles-Sims 1995; Peterson and McCracken 1998). Peters and McCracken propose that smacking is a common occurrence for only a limited time during the parent-child relationship and that societal norms probably redefine how children's behaviour should be controlled as the child ages. It has also been shown that boys are smacked more often than girls (Peterson and McCracken 1998; Straus 1994). Fathers smack their children less often than mothers and discontinue smacking when the child is younger (Peterson and McCracken 1998), which the authors of this study suggest is due to mothers being the principal caregivers of children and therefore spending more time with children, resulting in them dealing with more episodes of negative behaviour. It is therefore pertinent to elicit and explain parents' understanding of differences between mothers and fathers in their approach to managing children's behaviour.

Hastings and Grusec (1998) looked at the relationship between parents' discipline techniques and the goals they were aiming to achieve using questionnaires with 198 parents. Discipline techniques can be of three types: power assertion, reasoning, and responsive behaviour or negotiation. Power assertion is likely to elicit immediate compliance, although it may also engender anger and resistance in a child, thus undermining the internalisation of standards for behaviour. Reasoning is thought to foster internalisation. Responsive behaviour, including displays of warmth and the use of cooperation and negotiation, may reduce a child's negative affect and resistance, persuade a child that the parent is flexible and reasonable, and develop a child's ability and willingness to compromise. Goals are classified as parent-centred, child-centred or relationship-centred. The present study uses qualitative methods to elucidate how situational factors affect parents' approach to disciplining their children.

The studies reviewed suggest that most parents smack their children, especially when they are at the pre-operational stage when they are most likely to display very negative behaviour and are not yet amenable to reasoning. Although parents consider that smacking is sometimes justified, they would prefer to use alternative techniques where possible. It may be that parents' lack of knowledge of 'time out,' coupled with their erroneous interpretation of young children's inappropriate response to verbal reasoning, leads to young children receiving physical punishment which could be avoided. The literature review suggests that discipline is an area of concern to parents and that examination of this area is very pertinent to the current study's analysis of parents' experience of their role. Apart from that of Backett (1982), all the studies identified were carried out in North America and it is relevant to look at British parents' approach to this issue. Also, most of the studies are quantitative and there appears to be a need for more qualitative research in this area.

This chapter concludes with a review of the literature pertaining to social support as a focal concept and the role it plays in parents' lives. Firstly the concepts of intimacy and social support are introduced, before proceeding to a review of the literature

about the contribution of extended family and friends in providing social support to families with young children.

2.9 Intimacy

Jamieson (1998) understands intimacy to be “a very specific sort of knowing, loving and ‘being close to’ another person” (p1). She proposes that this kind of intimacy requires that the people involved are of equal status, and questions whether the intimate relationship is gradually replacing kinship as the ideal in personal relationships, with people rating having good relationships as more important than being part of a family. This would have enormous implications for parents and children for whom traditionally the extended family has provided an important and stable infrastructure for the rearing of children.

Jamieson (1998) reviews the history of intimacy. In the pre-modern/ pre-industrial era, people had relationships with family, neighbours and friends because of traditions and necessity, and there was little privacy. There was also a highly ordered social hierarchy which precluded the formation of equal relationships. During the modern/ industrial era, the family household became a private domain, and relationships of marriage and parenthood became increasingly intense and romanticised. Jamieson (1998) notes that many of the community studies carried out in the 1950's and 1960's focused on homogenous working-class communities centred round particularly heavy industries providing jobs to a stable population of local workers and their families over several generations. She proposes that findings from these studies suggesting the presence of a strong community spirit may have been wrongly generalised to other, dissimilar populations. Contemporary researchers use the term ‘social network’ rather than ‘community’ in recognition of the fact that important personal relationships may not be found in one place; the significance and meaning of any type of intimate relationships can best be understood by looking at the totality of people's intimate relationships (Allan 1989). This approach does not assume that a person's social network will be interconnected and members may never meet or even be aware of the existence of others in the network. Fischer (1982) interviewed over 1000 adults in fifty localities in the USA in a study to compare

social networks in urban and rural areas. Urban settings were associated with social networks made up from separate and unconnected social worlds; there was greater specialisation in relationships, less involvement with family and neighbours, and a larger circle of friends in urban areas than in rural districts in which people had more contact with family and neighbours, had fewer friends, and had 'multiplex' relationships in which there was a range of ways in which people did things for each other and spent time with each other (Fischer 1982). Although the findings must be extrapolated to the British situation with care, they suggest that parents' social networks in the large Scottish city where the present study was undertaken may differ considerably from those of parents living in a more rural setting.

2.10 The role of social support in parenting

Social support is a concept that has been studied both from theoretical and research perspectives. Initially, when social support was studied in the 1970's and early 1980's, it was conceptualised in concrete terms, to denote an interaction, person or relationship (Veiel and Bauman 1992). However, since the mid 1980's, the term has gradually come to mean "abstract characteristics of persons, behaviours, relationships or social systems" (Veiel and Baumann 1992 p2). More recently, a multi-dimensional taxonomy has been used to define social support, involving support networks, supporting behaviours and perceived support (Cohen 1992). Other facets relate to the interaction between the provider and recipient of social support, as well as perceptions of support compared with the support given, support needed compared with support given, negative support, and recipient and provider characteristics (Cohen and Syme 1985). In looking at social support in relation to parenthood, therefore, it seems vital to try to discern the processes underlying the relationships involved, rather than assuming that parents with apparently similar social networks are equally well supported.

Cutrona and Russell (1990) suggest that for social support to be effective the appraisal of the situation by provider and recipient must match. Thus some parents, for example, might see help from grandparents as intrusion. Tilden (1986) proposes that different types of support may be needed at different stages of a life event, which

in terms of parenting may involve the provision of practical help in the early days and emotional support later on. The reasons for providing social support also require consideration, and according to Jung (1988) providers of support assess factors such as the recipient's responsibility and the costs and potential benefits to the provider. Thus, for example, grandparents might consider that by helping with the care of their grandchildren, their children might be more likely to be attentive to them in their old age. People's perceptions of support may differ from the actual support given or available (Sarason et al. 1990), although Vaux (1988) argues that "...in most cases, the perception of support or its absence would seem likely to have an effect regardless of its actuality" (p16). Previous research therefore demonstrates the need to explore parents' experience of social support rather than assuming that the presence of family and friends equates with meaningful support for families.

While social support has positive connotations, Coyne and Delongis (1986) point out that social networks may cause stress and that many potential sources of support may be more demanding than helpful. It is therefore important to be aware in the present study that parents' social networks may present stresses as well as supports.

Antonucci and Jackson (1990) propose that a balance between individuals in giving and receiving social support is important for well-being and overall satisfaction with the social support network. Parents are therefore likely to benefit from being in a position of mutual reciprocity rather than only being in receipt of support, and it is important to explore their experience of giving, as well as receiving, support and the meaning they ascribe to both.

2.11 The role of extended family in parenting

Before industrialisation, most people's livelihood depended on remaining within the family unit. Industrialisation and urbanisation meant that people could earn a wage independent of their families. The relationships which individuals now have with their extended families depend more on a sense of obligation and responsibility than on economic necessity.

In the 19th century, when families were larger and more spaced, older children were often having their first children when their parents were still adding to their own families. Younger children were likely to be at home when their parents were needing care (Hareven 1978). Now it is common for three adult generations to coexist, which makes long-term reciprocation a realistic possibility. However, Anderson (1985) argues that just as this mutual support has become possible, grandmothers are now in paid employment when their grandchildren are young and most women are working at the time when their own parents require care.

Young and Wilmott's (1957) study of 45 families in Bethnal Green was one of the first accounts of family life informed by research, where mothers and daughters appeared to share household tasks and childcare. In this period, the other seminal work on family relationships was Bott's (1957) study, based on an intensive study of 20 married couples, where more variety in exchange of social support was demonstrated. She argues that frequent contact among members of extended families promotes the provision of practical support because it puts pressure on family members "to keep up their kinship obligations" (p 133). There have been many social changes since these studies were undertaken which are likely to affect relationships within extended families; for example, single parents and dual-earner parents may be less able to reciprocate support than those living in the traditional families of the 1950's, reorganised families are likely to have complicated extended family networks, with, for example, more than two sets of grandparents, and more families are isolated geographically from their extended families than was the case when the studies were undertaken. It is therefore relevant in the present study to look at the role of the extended family within the context of contemporary family structures and functioning.

Cornwell's (1984) study of the relationships of 14 households in Bethnal Green in the 1980's makes specific comparison with Young and Wilmott's earlier work. This later work reveals some examples of extensive sharing of support between mothers, daughters and sisters, although in relation to child care, she documents how assistance given by mothers to daughters is more extensive than between sisters.

Bell, McKee and Priestey (1983) found that maternal grandmothers usually care for older children following the birth of a new baby, a specific short-term situation. Wilson (1987), in her study of 61 white mothers conducted in London, found that none relied upon their children's grandparents to care for children while they themselves went out to work, but most saw grandmothers as support they could use on a more casual basis for baby-sitting and as help in emergencies. These later studies indicate a move away from the 'corporate childcare' of the 1950's.

Finch (1989a) comments that practical support between relatives is highly gendered, with the female members much more involved than men, who usually only assist with typically 'male' activities, such as gardening and decorating (Pahl 1984).

In relation to emotional support and advice on childcare, Young and Wilmott (1957) document how daughters turned to their mothers when they were anxious about their children's health or unsure about some aspect of childrearing. Blaxter and Paterson's (1982) more recent study of common-sense ideas about health, illness and health services held by 58 three generational families, undertaken in Scotland, suggests that mothers remain an important source of advice to, and support for, young women who are concerned about health matters in relation to their own children - at least for working class women, with whom their study was concerned. At the same time, some of the grandmothers believed that they received more advice and support from their own mothers than they gave to their daughters and all were concerned to ensure that their support did not amount to interference. It is therefore timely to demonstrate whether the role of grandmothers in advising about childcare has changed between the 1980's and the present time.

There is evidence that younger people expect to transfer the source of their main emotional support to their spouse when they marry. Mansfield and Collard (1988), in a study of marriage, interviewed 130 couples separately three months after marriage. They found that most expected to apply the contemporary idea that marriage should involve close psychological intimacy to their own situation, and many of the women especially were rather disappointed as a result. Data from this study also show that some people do retain relationships which they use for

confiding and support, especially with their mothers, and this is regarded as appropriate, especially for women to get support with concerns that essentially are 'women's business.' In view of the difficulties experienced by women in the transition to motherhood and the limited role fathers appear to have in childcare, discussed earlier, it might be expected that mothers would seek support from other sources.

In relation to seeking emotional support, O'Connor and Brown (1984) examined the circumstances under which women develop very close relationships, in the context of how women manage disruptive life experiences. They interviewed 60 working class mothers living in London, aged between 20 and 42 years, whose oldest child was no more than 15 years old. It is clear from these data that relatives are by no means the major support in these circumstances. Less than one third of respondents who had a mother living included her as a person to whom they felt very close, and hardly any had what could be described as a 'true' close relationship with their mother. This study further shows that one can distinguish clearly between the kind of very close relationship which will provide emotional support in time of crisis, and closeness in other senses. Women had relationships with relatives which were close in terms of the frequency of contact, but which did not form the basis of a confiding relationship. This study underlines the highly selective nature of relationships which can be used for emotional support in distressing circumstance, and shows that such support is not a routine feature of family relationships. The present study explores the ways in which parents understand the value of different sources of support in meeting their needs in childrearing.

Finch (1989b) developed a framework for understanding the foundations of support between adult kin in the context of contemporary Britain. She suggests that duty, obligation and responsibility are the defining marks of the special character of kinship and are present in these relationships in a way not replicated even with close friends.

Finch and Mason (1993) in their study of family negotiations, involving interviews with 88 respondents, found that family is seen as a safety net to fall back on as a last

resort if things go drastically wrong, especially if there are unexpected traumas or disasters. The data from this study suggest that people try to avoid relying on help from relatives rather than routinely expecting to call on it. Finch and Mason (1993) have demonstrated "a continuing and strong sense of individualism in social life," (p179), with people looking for "intimacy at a distance" (p179). As McFarlane (1978) pointed out, Britain has a model of family life in which kin relations outside the nuclear family are relatively unimportant by comparison with other societies in Europe. In exploring contemporary parenthood it is therefore pertinent to look at how autonomous parents are by choice as well as by limitations of support available.

Responsibilities of parents for young children and of spouses for one another are subject to legal definition. The duties attached to other adult kin relationships have not been legally defined in Britain since the abolition of the Poor Law in 1948. Before that, grandparents as well as parents had a responsibility to support children of immature years. Cunningham-Burley (1985) carried out a qualitative study of grandparents, involving interviews with eighteen sets of grandparents once before and twice after the birth of their first grandchild, in order to document the process of becoming a grandparent. She found that grandparents saw their role as being bounded by certain rules or guidelines which served to restrict their involvement with grandchildren. The main restrictions on their involvement were related to the grandparents' wish not to interfere with their children's lives, having to share grandchildren with the other grandparents and not spoiling grandchildren.

Cotterill (1992) in her exploratory study of relationships between mothers -in-law and daughters-in-law, involving interviews with ten mothers-in-law and twenty-five daughters-in-law, found that paternal grandmothers, whilst welcoming grandmotherhood as a positive and enjoyable experience in middle-age, did not wish to use it as an opportunity to resume mothering or to repeat the more demanding aspects of childcare. Both these studies of grandparenthood suggest that grandparents, like parents, see their role as being limited and well-defined, partly because they do not want to intrude in their children's lives and also because they

have other interests which they want to pursue. It is therefore pertinent to examine the role of grandparents from the parents' point of view.

However, Finch and Mason (1993) found that there was a sense that a person belongs to their kin group in a way which is not true of other social groups of which they might be a member. Especially in relation to the family of origin, a kin group is the group into which a person is born, in which the membership is in no way chosen and where relationships still exist throughout life even if they are left dormant. It therefore exists as a ready-made context within which responsibilities can appropriately develop and also are very likely to develop as people interact with each other. It is precisely the same set of features which also makes the kin group an appropriate safety-net to use as a last resort. It is therefore relevant to explore the impact of the birth of a first child on the significance to parents of the extended family.

The consensus of the recent literature therefore suggests that support from extended family is limited, and that the nuclear family operates as a discrete unit in relative isolation from the kin network. Routine help and sharing of responsibility for children does not seem to be a feature of the modern extended family. However, the extended family is portrayed as providing the nuclear family with a sense of identity and as providing a safety net to complement or substitute for parents in time of particular difficulty. These findings have relevance to the present study as they suggest that support from extended family cannot be assumed even when they are living close to parents and that parents may be looking for other sources of help.

Support between siblings contrasts with support between parents and children in that it depends far more on personal liking and also in the way in which reciprocal exchange is important (Finch 1989b). The sister-sister relationship often bears many similarities with friendship in terms of sociability and emotional support, although sisters are more likely than friends to provide practical support (Wellman 1990).

Finch (1989a) suggests that family responsibilities are worked out by people learning from their past experience of living in a given society how to interpret other people's behaviour and how social life works customarily. These rules themselves are subject

to change over time, and it is precisely this process of applying them to particular situations which develops and changes them: people feed back the understandings which they have developed in particular situations into their more generalised understanding of social rules. Thus the role of family in relation to parents with young children can be redefined in response to changes in society, such as the increasing number of mothers and grandmothers in employment and the increasing emphasis on fathers taking a more active part in bringing up children.

Finch (1989a) also discusses the concept of 'public morality' which people use when working out their family commitments. People consider how others, both those directly involved in the situation and those outside, will judge their behaviour in relation to identifying and fulfilling family commitments. In Mediterranean societies family reputation is very important and has to be guarded jealously, where the concepts of honour and shame apply to the kin group as a whole as well as to individual reputations. This particular concept of family reputation has not been part of British white culture, but that does not mean that reputation is unimportant.

While it has generally been assumed that support from the extended family emanates from a sense of duty, Finch (1989a) gives the impression that the motivation to offer support to extended family may originate more from a desire to avoid adverse criticism from people of significance to the provider than from a sense of duty to the recipient. The literature gives little indication that extended family might be involved with bringing up children for sheer pleasure. The literature reviewed therefore demonstrates the importance of extended family to parents and also highlights the limitations of this source of support.

2.12 Role of friends in parenting

The literature relating to extended family and its strengths and limitations has been explored. Literature pertaining to the friendship, the other main source of informal support, is now examined.

Friendship, despite its significance in our everyday lives, has received little attention from social scientists. According to Allen (1989), friendship is often seen "as an

extra, as something that adds a little flavour to life but which of itself is relatively unimportant in the nitty-gritty social organisation" (p2). Allen (1989) proposes two related reasons for the rather isolated way in which friendship patterns are analysed in friendship research. Firstly, friends are much more difficult to define than family, neighbours and work colleagues. Secondly, friendship itself is not institutionalised in any real sense in our society.

Friendship has generally been studied as one aspect of other areas of research interest such as ageing (Jerrome 1984) rather than as a topic in its own right. For example, studies of organisations - bureaucracies, schools, factories etc - have often pointed to the way in which informal relations of a friendship type help to oil the more formal channels of communication and command, thereby enabling individuals to achieve or counter the organisation's goals as suits their interests (e.g., Westwood 1984; Litwak 1985). Similarly, research into personal crises -for example, unemployment, divorce or bereavement -has been concerned with the role played by friends at these times, as well as the impact these events have on the patterns of friendship maintained (Bankoff 1981; Morris 1984).

Some studies have been carried out to explore women's friendships within a culture in which women's relationships with their husbands and children are seen as more conducive to their happiness and well-being than any other relationship. Oliner (1989) noted in her study, involving structured interviews with 21 women, that women were more able to identify easily the unique provisions of their friendships than the unique provisions of their marriage. Gouldner and Symons Strong (1987) in a qualitative study of 75 American upper and middle-class women aged between 30 and 65 years, found that friends were considered essential to their sense of well-being and their ability to cope with difficult family situations. Typically in these studies, it is clear that the husband-wife relationship is ideologically dominant; most of the women in these studies would have preferred to have shared their routine activities and everyday experiences with their husbands rather than with their friends. The common experience was that men in their lives were simply not interested in these issues, hence potentially increasing the importance of their female friendships, if not

their perception of their value. These studies suggest that an exploration of friendship in the context of motherhood is pertinent to the present thesis.

Oliker (1989) suggests that the friendships between the women in her study enabled them to tolerate the contradiction between the vision of a companionate marital relationship and what she called "the actuality of marriage" (p156). Thus Oliker's work suggests that friendships between women maintain marital structures, while at the same time creating personal space and autonomy within them. Oliker describes how friends generated empathy for a woman's husband and framed the marital situation in such a way as to enhance his image. They used humour to defuse situations and they reinforced their sensitivity to their children's needs and what Oliker calls their "communal responsibility" (p 142). Gullestad (1984), in a study of Norwegian women involving participant observation and unstructured interviews with 15 working-class married mothers of young children, suggests that women use their friends to work out ways of handling their lives. In particular, friends play an important part in working out ways of dealing with their husbands and the tensions potentially implicit in the conflicting cultural expectations of marital stability and sexual bliss. It therefore seems relevant to explore the role of mothers' friendships in helping them to cope with the stresses of parenthood when considered in the context of there being limited support available from extended family, a situation which is likely to make the relationship between parents more intense and more liable to strain than when there are family members with whom to share the stresses and responsibilities of childcare. Friends are therefore likely to contribute to the relationship between parents in two ways: by making the mother feel more positive about her partner, and by providing her with another source of support thereby reducing the onus on the partner to provide support (Gullestad 1984).

Frequency of face-to-face contact has been widely used in studies of friendship, but the validity of this method as an indicator of the closeness of relationships is questionable. Thus Gouldner and Symons Strong (1987) found that people who were rarely seen were sometimes identified as close friends. Frequently, these

relationships were characterised by a sense of togetherness and a history of shared experiences.

Weiss (1969) introduced the concept of “a fund of sociability,” whereby people have a limited and stable need for intimacy and other socio-emotional resources. While Weiss suggested that when this need is met by the marital relationship there is little need for other relationships, Bulmer (1987) argued that friendship is not a substitute for deficiencies in the marital relationship because, as a result of cultural and social factors, the majority of men and women in Western society have different values and beliefs, with men valuing competitiveness and deriding emotional vulnerability.

Gullestad (1984) draws attention to the processes operating within women’s friendships in drawing up guidelines:

“about the rightness and wrongness of childrearing practices, in division of labour between spouses, in relations with parents and parents-in-law and other relatives...Their relationships with men are the focus of an intensive interest.” (p220)

Thus women are likely to work out their approach to childrearing and other related issues, which is an important part of the transition to motherhood, (see section 2.5), through discussion with other women.

Mothers in full-time employment may have significantly smaller and less child-centred networks than mothers working part-time or not in paid work, since they are less available for day-time contact (Brannen and Moss 1991). Consequently, mothers in full-time work may become more emotionally dependent upon their partners, even as they gain greater economic independence. Single parents working full-time are likely to be especially isolated. Bell and Ribbens (1994) suggest that this raises the possibility of a different form of isolation being experienced by mothers in full-time employment. However, some studies (e.g., Griffin 1985; Green et al. 1990) suggest that relationships at work are an important and very real aspect of many women’s work situations. Sharpe (1984) suggested that these relationships were often the most positive aspects of the routine alienating jobs done by women in their studies. Leslie and Grady (1985) found that in their study of changes in mothers’ social networks and social support following divorce, in which 38 mothers were interviewed shortly

after divorce and one year later, the workplace was the second most common source of significant relationships (with kin being the primary source). Oliner (1989), however, found that although only roughly a quarter of her respondents saw co-workers as best friends, the majority of those who did so saw them as 'best' or 'closest' friends. Allan (1989) suggests that the real significance of work relationships may only become apparent when they do not exist, for example, when women are at home with young children. It is therefore important to explore the ways in which mothers' employment status provides and limits their social support.

The literature on friendship tends to be concerned mainly with women's friendships generally, with little research having been carried out specifically on the role of this support on parenting, although many study participants were parents and there are references to family functioning, mainly in relation to the relationship between partners. Also, most of the authors of the studies reviewed are North American, with the exception of Allen (1989). However, the literature on friendship does suggest that friends and work colleagues play an important part in supporting parents in their role, especially in view of the limited support which many parents receive from kin. Even when family are supportive, the reciprocal and equal relationship which is a feature of friendship appears to result in parents benefiting from the complementary aspects of both sources of support. The present study addresses the role of friendship specifically in relation to parenting, within the British culture.

2.13 Comparison of roles of family and friends in parenting

Social support from family and friends appears to have similarities and differences. O'Connor (1992) suggests that the association of friendship with intimacy and of kinship with caring has been facilitated by the tendency, prior to the 1980's, not to differentiate between emotional caring and practical tending. However, this assumption is now being challenged. Two-fifths of Finch and Mason's (1993) sample agreed with the statement that children have no obligation to look after their parents when they are old, while the majority said that they would prefer care not to be given by the family in a variety of specific situations which were presented to them involving elderly parents.

Allan (1989) and Wellman (1990) also found that friends could offer long-term practical help without considering issues of reciprocity. Wellman (1990), in a qualitative study involving interviews with 29 randomly chosen individuals in East Yorkshire, found that people who did not have active kinship ties tended to develop relationships with non-kin to substitute for the support which traditionally would have come from extended family. It is therefore pertinent to look at the roles of family and friends in contemporary parents' lives and the similarities and differences between these two main sources of support. In a large city, with a mobile population, where the study was carried out, it might be predicted that many parents would look to friends to compensate to some degree for extended family.

2.14 Summary and discussion

Looking at childhood from a historical perspective demonstrates that the ideology of the family has changed from having a focus on children's duties and obligations to their rights, with child welfare gradually being concerned with ensuring that children reach their full potential rather than simply surviving childhood. The impact of social factors on parenthood throughout the history of childhood highlights the need to take these factors into consideration in the present study. The transition to parenthood is portrayed as problematic for many parents, with adaptation to motherhood and fatherhood presenting some similar problems, but with fathers adapting more slowly and their involvement being more optional, because of social factors. The literature review suggests that mothers benefit from working outside the home, but still retain the overall responsibility for childcare due in part to both fathers and mothers tending to uphold a more traditional view of family life than is required for truly egalitarian family functioning. It is therefore timely to include in the current study an examination of contemporary parents' understanding of the impact of mothers' paid employment on mothers and the other family members in the light of political moves to encourage mothers to work outside the home. Parents appear to experience ambiguity about effective ways of disciplining children, particularly in relation to the use of physical punishment, to which most parents admit to resorting because of a lack of knowledge about alternative strategies. There appears to be a need to explore

parents' approach to disciplining their children, both the strategies they employ and their attitudes to the management of their children's behaviour. The review of the literature relating to social support suggests that the traditional role of the extended family is diminishing and that there is more overlap between family and friends in terms of the provision of social support to families; it is pertinent in the present study to explore the different representations of these sources of social support to contemporary parents and to examine too the ways, if any, social support affects the experience of parenthood. Social support is also portrayed as being a complicated issue and the examination of this area requires far more than a simple count of people who appear to be in a position to offer support. The need to explore the meanings ascribed by parents, the possible negative effects and the place of reciprocity in the current study is highlighted. The relative contribution of friends as opposed to extended family appears to be increasing, both in the amount and type of support offered, and the current study therefore addresses the relationship between these sources of support in the lives of parents.

The lack of contemporary British studies of the experience of parenthood suggest that the current study is important. While topics such as approaches to discipline have been researched, these have generally been carried out in isolation rather than within the context of other relevant factors. Therefore the present study, focusing on aspects of parenthood which are of concern to parents themselves, allows the themes identified to be analysed within the context of other issues of relevance to parents themselves. Moreover, the review of the literature demonstrates the salience of examining parents' experience of the health visiting service within the context of their experience of parenthood. The literature suggests that it is important to look at topics such as parents' reflections on the transition to their new role, the relationship between mothers and fathers as it affects childcare and other aspects of family life and the role of informal sources of social support in order to interpret their perceptions of the health visiting service in a meaningful way. It appears to be important to understand how parents experience childrearing in order to analyse the role of the health visiting service, both generally with parents of young children and also with individual families.

Against this background, the literature of relevance to the analysis of parents' experience of the health visiting service is now reviewed.

CHAPTER 3: HEALTH VISITING IN RELATION TO FAMILIES WITH YOUNG CHILDREN

3.1 Introduction

The previous chapter was devoted to a review of the literature on aspects of parenting which are relevant to families of young children. In the present chapter literature relevant to the exploration of parents' perspectives on the health visiting service will be appraised. The chapter is set out in three sections, which overlap to a considerable degree.

The chapter begins with a résumé of the history of the health visiting service, placed in the context of other developments in health and welfare movements, and consideration of theoretical perspectives relating to the study of family life and professional involvement with families. The literature relating to contemporary health visiting practice is then explored, taking as a starting point parents' views of the service, which is fitting for a study focusing on parents' experiences. This sheds light on some of the processes involved in health visiting practice, and these processes are then examined from the practitioners' point of view. The literature pertaining to the parent-health visitor relationship is discussed before reviewing the literature relating to the theoretical basis of the health visitor-client relationship.

3.2 Setting health visiting within a historical context

Public health is defined as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society" (Acheson 1988). Cowley (1996a) describes the history of health visiting and the ways in which the health visiting service has evolved in response to changes in approach to public health. Ashton and Seymour (1988) describe four distinct phases of public health, the first three associated with environmental change, personal preventative measures and therapeutic interventions respectively, coming together in the fourth phase to form the 'new public health' approach.

Early in the nineteenth century, poverty and poor housing, resulting from industrialisation, were the main public health concerns, being considered the cause of the epidemics of infectious diseases which were rife at the time (Ashton and Seymour 1988). Health visiting started in Salford, with the establishment of the Ladies' Sanitary Reform Association, who were charged with the responsibility of improving the health of families living in slum housing conditions. These forerunners of the health visiting service, who were middle-class women working in a voluntary capacity, felt that they were not able to get across their advice to the families with whom they were working. In 1867, the first paid health visitor, 'a respectable working class woman,' was appointed to work with families by providing practical advice about hygiene and distributing chloride of lime and pails and brushes. Cowley (1996a) points out that the health visitors during this first phase used what is now termed 'skill mix,' provided a universal and comprehensive service, and used a holistic approach to public health, paying heed to social factors and focusing on families and whole communities rather than individuals.

The second phase, which started at the turn of the twentieth century, was characterised by a changing emphasis to individual, personal and preventive services brought about by medical innovations such as immunisation (Cowley 1996a). Concern about poor health among working class families led to health visitors being employed to address the problems of high infant mortality and poor child health, which were attributed to mothers' fecklessness. Health visiting was now under the direction of medical officers of health and was targeted at families judged to be in need.

The third phase of the public health movement, in the 1930's, coincided with the 'therapeutic era,' when proven medication, such as insulin and sulphonamides, became available (Ashton and Seymour 1988). Hospital based medicine received more interest than community health, and health visiting during this era was based on the medical model, focusing on disease prevention through educating, advising and preventive activity, with infant welfare as a priority.

With the advent of the National Health Service in 1948, public health was of little concern as the emphasis was on eradicating ill health by medical intervention, with the accompanying welfare policies being considered sufficient to abolish poverty and social need. However, when these predictions were not realised, the medical model was widely criticised in the 1970's (Bunton and McDonald 1992). Gradually, as noted by Cowley (1996a) there was a move towards primary health care as the main focus of health care provision, and to health promotion becoming more holistic than the traditional health education strategies had been.

These changes heralded the emergence of the 'new public health,' which Ashton and Seymour (1988) refer to as the fourth and current phase of public health.

The principles of health visiting were re-examined and redefined at the same time as the 'new public health' was unfolding. The key principles of health visiting were identified by the Council for the Education and Training of Health Visitors in 1977 as:

- the search for health needs
- the stimulation of an awareness of health needs
- the influence on policies affecting health
- the facilitation of health-enhancing activities

Cowley (1996a) notes that:

"Health visiting and 'the new public health' share a holistic, humanistic philosophy, and a broad, socially-based belief in the value of health. These beliefs are translated into practice in an approach which requires concurrent emphasis on each of the functions (environmental change, personal preventive measures and therapeutic interventions) which had occurred separately in earlier stages of public health endeavour." (p314)

In the new NHS, there is a pressure to target services according to need, and the definition and assessment of need is related to the ability to demonstrate the effectiveness of the interventions delivered in response to these needs (Stevens and Gabbay 1991).

While the new NHS creates new pressures and difficulties for health visitors, the involvement of consumers in the planning and delivery of health care puts parents centre-stage in planning for the health visiting services which will be effective in contemporary times. The previous chapter exposed problematic aspects of family life such as the difficulties experienced during the transition to parenthood and the diminishing role of the extended family in providing support to parents. Parents are therefore likely to be looking to other sources for advice and support in raising children. It is therefore relevant to investigate what role, if any, the health visiting service plays in parents' lives.

3.3 The involvement of agencies in family life: social policy and social control

Health visiting in relation to working with families with young children involves tensions: between the public interest in child welfare and the private lives of families, between the lay and professional sources of involvement with families, and between the supporting and surveillance aspects of the health visiting service.

Health visiting shares some similarities with modern medical practice, which, Nietzsche (1974) argues, constitutes a new form of control. According to Nietzsche, medical science provides a language which can be used to construct notions of pathology and illness, which enables professional agents to interpret social reality in accordance with their own values and professional setting. Foucault (1974) argued that we see what our language allows us to see. Professional status confers the power to talk authoritatively and with legitimacy about a range of matters from the world of medicine and 'social pathology' in the modern welfare societies in the west. Problems and 'pathologies' become visible because an increasing variety of sources of knowledge, such as psychology, sociology and social work, combine with new and emerging forms of professional power, allowing practitioners to define, classify, and prescribe remedies for an infinite number of problematic social behaviours and 'pathological' conditions. Knowledge and power are, according to Foucault, an indivisible pairing. This understanding of professional power would suggest that health visitors are in a position to prescribe how children should be cared for and to

define good and bad parenting, for example, by discussing how parents should manage their children's behaviour in terms of psychological theories.

Foucault (1977) suggests that the application of science to everyday life leads to an inevitable uniformity in human affairs. Professional practitioners, particularly from the fields of health and welfare, who are charged with the responsibility of controlling both medical and social deviance within large populations, perpetuate this process, which Foucault calls rationalisation. Foucault proposes that rationalisation leads to normalisation, which is a mechanism of social control well adapted to ordering the lives of large populations effectively without recourse to instruments of coercion, but which puts pressure on people to conform to social norms through self-control. An integral part of this process is what Foucault (1977) called *normalising judgement*, which refers to the power yielded to professional practitioners, such as social workers, health visitors and others involved in community medicine, to judge each individual against some common understanding of the boundaries of normality. In this way, welfare practitioners are viewed as key figures in monitoring and effecting change in family life. The current move to discourage parents from using physical punishment as a means of disciplining children (see Chapter 2.8) might be proposed as one example of normalising judgement. Dingwall and Eekelaar (1988), drawing on the work of Donzelot (1980), describe how the state manages to exert control over family life without direct involvement in what is considered to be a private sphere by involving charitable organisations and professionals such as health visitors and social workers. Health visitors' involvement in the promotion of childhood immunisation might be interpreted as indirect control of families by the state. Dingwall and Eekelaar (1988) describe how in the nineteenth century the major public health concerns relating to epidemics of infectious diseases were blamed on poor parenting and domestic hygiene. The solution to these problems was seen to lie in raising the profile of motherhood. Today it might be argued that health visitors have a role in providing interventions concerned with the promotion of parenting skills which might help to address the problems of antisocial behaviour of young people and juvenile delinquency which appear to be of concern to society. The

present study explores whether parents see health visitors as trying to impose control over their family life.

In analysing practitioner-client relationships, there are tensions between the perceived need for public debate and policy about family life and the privacy which is associated with the family. Rodger (1996) suggests that direct political intervention into the private affairs of family living is generally considered to be unacceptable in liberal-democratic societies, this prohibition having been established much earlier in history when families had a patriarchal structure. Other means of influencing family life which preserve the aura of privacy which surrounds the institution of the family have had to evolve and this is likely to become increasingly important in light of the diminishing role of the extended family, which was discussed in the previous chapter.

Wolfe (1989) argues that the traditional institutions which in the past set standards of morality and normative certainty, such as churches and families, are no longer capable of generating a consensus about the rules of moral obligation. He suggests that:

“the gap between the need for codes of moral obligation and the reality of societies that are confused about where they can be found is filled, however uncomfortably, by the contemporary social sciences.” (p221)

In view of the weakening influence of the church and extended family it is important to examine whether parents expect agencies such as the health visiting service to take on a role in establishing standards for bringing up children. The review of the literature suggests that resentment of intrusion of agencies into the private lives of families and an expectation of guidance about childrearing are bound to result in tension. The present study examines parents' understanding of the health visiting service with respect to these two parameters.

3.4 Health visitors as agents of social control

Dingwall (1982) suggests that the organisation of health visiting represents “a compromise between enforcement and libertarian values” (p340). The health visitor

is concerned with public health but the private sphere of home and motherhood is the target for tackling the problem.

Abbott and Sapsford (1990) discuss whether the description “policing the family” is applicable to health visiting. While health visitors have no statutory powers, they visit families to advise on a range of health and childcare issues, and judge parents to be good or bad. Rodger (1996) draws attention to the blurring of the boundaries between ‘caring’ and ‘controlling’ functions in professional practice. He suggests that the concepts of rationalisation (the application of medical science to the regulation of family living), normalisation (the inculcation of ‘good’ domestic habits through schooling and advice) and panopticism (the surveillance of family and household) are apt for the description of the professional role of the health visitor. Recent developments in health visiting practice strive to create a very different ethos from that portrayed by Rodger (1996). These include the Child Development Programme (Barker 1987), which involves monthly visits to parents of first-time parents with the aim of empowering parents in their role, and community development approaches which involve working in partnership with communities and using resources from within the community to identify and address health needs.

Symonds (1991) compares district nursing and health visiting in relation to the creation, function and meaning of the two occupations. Symonds contends that because district nurses carry out ‘hands on’ work, wear a uniform and are constrained in their choice and timing of activities, whereas health visitors are involved in ‘hands off’ activities, do not wear a uniform and have more autonomy than district nurses, health visitors appear to have greater status than their district nurse colleagues. Symonds suggests that because district nurses focus on illness, they are not a challenge to female authority, whereas health visitors challenge the ownership of child care by advising and informally attempting to regulate and control another female, the mother. The health visitor can construct images of competent, incompetent, or indeed ‘dangerous’ mothers, through using the professional training and language associated with her role. While Symonds’ depiction of health visitors may be valid in relation to their role in detecting and monitoring concerns about the

safety and welfare of children, it does not reflect their role in supporting families. For example, it has been shown that supportive home visits from health visitors are effective in the treatment of post-natal depression (Holden et al. 1989). The present study therefore aims to examine parents' perceptions of the health visiting service in terms of surveillance and support.

Bloor and McIntosh (1990) draw on Foucault's concept of power and surveillance in their analysis of the forms which surveillance take in the professional-client relationship in health visiting, and the forms of resistance that such surveillance evoke. Foucault understands power to be found solely in its exercise, linked with knowledge, in social relationships. Surveillance involves a power relationship, and Foucault (1973) describes the "clinical gaze" of those who carry out the surveillance role as "the eye that knows and decides, the eye that governs" (p89). According to Foucault, power provokes resistance, which is central to his concept of freedom. Power is pervasive and so freedom is the possibility of practical revolt against power rather than the absence of power.

Bloor and McIntosh claim that health visiting interventions, especially those concerned with monitoring abuse and neglect and with the assessment of children's health and development, constitute surveillance. Bloor and McIntosh (1990) also argue that health education, because it involves knowledge, which according to Foucault, is always associated with power, also has surveillance at its core. Thus non-directive professional advice is a contradiction in terms, as the advice given depends on the assessment made of parents' skills and on the health visitor's definitions of acceptable standards, which may involve values and standards not shared by the parents. However, this claim could be refuted by health visitors using newer approaches to practice, such as community development which uses the community as the source of expertise and the Child Development Programme (Barker 1987) which emphasises the expertise of parents themselves.

Bloor and McIntosh (1990) distinguish between three different types of surveillance: covert or naturalistic surveillance, supervisory surveillance and surveillance by proxy or by the encouragement of self-reporting. In health visiting, naturalistic and

supervisory surveillance are not generally feasible, and so health visitors are forced to rely on surveillance by proxy or self-report. Health visitors rely mainly on self-report, encouraging their clients to furnish them with the information they require to monitor child care. As Bloor and McIntosh (1990) point out, health visitors are not well placed to counteract resistance; they have no right of access to parents' covert activities and may not know that concealment is taking place, and even when they do they do not want to antagonise parents by confronting them.

Bloor and McIntosh (1990), like Symonds (1991), emphasise the monitoring and surveillance role of health visitors while not acknowledging any interventions with the aim or result of providing support to families. This may be because the working class parents who participated in McIntosh's (1986) study perceived health visitors only in terms of social control, perhaps because they had ready access to support and advice from extended family and because it was still common at this time for health visitors to make unscheduled home visits which would tend to be seen in terms of social control.

The examination of the role of agencies working with families suggests that health visitors work in a sensitive area and that some families will inevitably perceive health visiting interventions as unwanted interference.

3.5 Involving parents in the study

The thesis is concerned with parents' experience of bringing up young children and of the health visiting service. The political background to the increased involvement of health service users in research is outlined and factors which have to be considered in adopting this approach are discussed before going on to review the literature relating to parents' views of the health visiting service.

Recent government reforms have promoted the involvement of users in designing and evaluating health services. The Griffiths Report (Department of Health 1988) introduced the concept of consumerism into health care and recommended that services should be tailored to the needs of individual patients and their carers, with a shift away from a professionally-led to a needs-led service. The White Papers

Working for Patients and Caring for People (Department of Health 1989a, 1989b), which formed the basis of the NHS and Community Care Act (Department of Health 1990), resulted in health services becoming more sensitive to consumers' needs. The Patients' Charter (Department of Health 1992) set out the rights and expectations of health service users. Designed to Care (Scottish Office 1998) and The New NHS (Department of Health 1997) again emphasised the need to consult health service users in Scotland and England respectively, about the planning and evaluation of services.

The term 'user-involvement' is used to describe a wide range of relationships between providers and recipients of health care, embracing a broad range of activities from simple information-giving to participation of users in decision-making (Poulton 1997). Barnes and Wistow (1992) suggest that user-involvement have two broad purposes: to make services sensitive to the needs and preferences of users and to include users in the design and evaluation of services.

However, problems with adopting this approach uncritically have been identified. Respondents may not understand the nature of the services on which they are being asked to comment or the key issues in evaluating or prioritising service provision (Pollock 1993). People may find it difficult to evaluate service provision if they do not know how the service could be different (Meredith 1993). Carr-Hill (1993) argues that good quality care, as judged by health care professionals, may have a poor satisfaction rating from recipients who do not share the same views as to what constitutes good quality care. McIver (1993) suggests that most patient satisfaction studies are structured questionnaires based on a review of other questionnaires, and identifies a need for more qualitative studies which explore patients' views on what constitutes a high quality service. Coote (1994) proposes that many studies are paternalistic with service providers defining both needs and measures of satisfaction. Judge and Solomon (1993) examined the answers of large national surveys which included peoples' attitudes to the health service. They found that people are consistently more critical of services than they are of people and that the closer individuals are to the experience of the service, the more likely they are to express

satisfaction with it. It therefore appears more useful to examine the needs of parents and the extent to which these are met by the health visiting service than to rely on parents' understanding of their satisfaction with the service.

3.6 Parents' views of the health visiting service

Parents' views of the health visiting service provide some insight into the health visiting process as well as providing a measure of their satisfaction with the service in meeting their agendas. An examination of parents' views is also useful in revealing their perceptions of health visitors in terms of interference, support and surveillance.

Collinson and Cowley (1998), in a small qualitative study to examine consumers' views of need and demand for a health visiting service, involving semi-structured interviews with the parents of nine children, asked parents to describe how they saw the role of the health visitor, and the positive and negative aspects of the service from the parents' perspectives. Parents' understanding of the health visiting role could be classified into five main components:

“general surveillance and monitoring of babies and children, giving advice and guidance on a broad range of subjects, including the whole family's health and practical help about facilities in the community, involvement in ante-natal care, the ‘social policing role’ of the health visitor, and building up a relationship.” (p245)

This portrayal includes both surveillance and support roles.

Collinson and Cowley (1998) note that the clients' knowledge of what the health visitor does directly correlated with what they had experienced; this was epitomised by one parent's comment:

“As I've needed more I've discovered more of what they're there for.” (p245).

The authors note that:

“If they (the clients) do not have a clear idea of what the service offers they will not know when to access it, or which of their

needs can be met by the service. Perceptions and expectations of the service are closely related to client satisfaction.” (p245)

However, health visitors are likely to emphasise their supporting role and minimise their role in surveillance of families.

Clark (1984) interviewed 26 mothers before the birth of their baby about their expectations of caring for the baby and the health visiting service they would receive, and again a year later to review both their experience of motherhood and the health visiting service they had received. The attribute of health visitors most important to mothers was approachability, which has also been demonstrated by previous studies (Graham 1979; Orr 1980; Field et al. 1982; Foxman et al. 1982). Clark highlights three findings from her study which, she notes, have been demonstrated in previous research: criticism of child health clinics by mothers in relation to rushed and public consultations (emphasised again by Sefi and Grice (1994) in a survey of 41 mothers), queuing and lack of continuity of care, lack of access to the service outside office hours, and a lack of understanding about what the service is for and how it works. It is proposed that the health visitor should define her own goals and share them with the client. Sixteen years after this paper was published, this recommendation seems inappropriate because of its authoritarian approach and lack of partnership and empowerment as a focus. The present study looks at contemporary parents' criticisms of the health visiting service.

Mayall and Grossmith (1985), in a questionnaire survey of 135 families from diverse backgrounds, with a child aged 18-36 months, explored mothers' views of the health visiting service. The most popular understanding of the health visitor's role was as helping mothers with problems identified by the mother, supported by 92% of respondents, followed by making sure that children were well cared for and offering general support (supported by 61% and 43% of respondents respectively). The health visitor was seen as an expert in child care and development, who could be called upon to discuss and help with major and minor problems and who was there for mothers' benefit. Mothers seemed to accept that health services staff had a right to monitor parental care and to intervene if they saw the need. Mothers in classes I and

II (as classified by the Registrar General), were more likely to see the health visitor as helping them with problems identified by them and as offering general support, whereas the mothers in classes IV and V were more likely to see the health visitor as checking up on the health and welfare of their children. This may have been because parents from poorer backgrounds were more aware of families who were being monitored by health visitors because of child welfare issues of which the study participants were aware as well as being the result of parents' direct experience of the health visiting service. Thus surveillance and providing advice about problems identified by parents were the main activities associated with health visiting for the study participants but mothers' viewpoints were influenced by their socio-economic backgrounds.

The attributes of a good health visitor most valued by mothers were friendliness and approachability, followed by willingness to respond to parents' perceived needs and respect for mothers' views. As this study used only survey data, it is possible that other aspects of the health visitor's role, which would have been revealed using qualitative methods, were overlooked.

Thompson (1986) examined the image of health visiting portrayed by the media. She describes the typical health visitor stereotype as:

“an overweight middle-aged lady in a hat, sitting down drinking tea and dishing out unsympathetic authoritarian advice, apparently oblivious of the fact that a marriage may be falling apart around her or that a child is being abused.” (p64)

Kelly (1996), in a telephone survey of a random sample of 175 members of the public, found that less than half of respondents knew that health visitors were all trained nurses, and there was no statistical difference between people with previous experience of the service and those who had had no contact with health visitors. While this lack of understanding of health visiting may demonstrate the low profile of the service, a comparison with other similar professions would reveal whether health visiting was in fact especially misapprehended.

Machen (1996) looked at the relevance of health visiting policy to contemporary mothers of young babies. Twenty first-time mothers were interviewed when their babies were between four and six months old. She found that the mothers described the service as effective, acceptable, relevant to their needs and facilitative rather than controlling or directive. While the policing aspect of the health visitor's role was acknowledged by some mothers, their own health visitor was seen as providing help, advice, support and reassurance. Many mothers expressed a preference for more contact, especially through home visits, which suggests that they wanted health visitors more involved in the private sphere of their family. Machen suggests that the contrast between the findings in her study and those of previous studies, where health visitors were described in negative terms, may reflect a change of approach in health visiting since the 1980's, with an emphasis on the use of non-directive interpersonal skills, and home visits being prearranged.

Cowpe et al. (1994), in a survey of 303 parents in Fife, also found that respondents had high levels of satisfaction with the health visiting service, 79% reporting that they always or usually got useful information, 98% finding the health visitor very easy or fairly easy to approach and 98% feeling that the health visitor was helpful. The study is limited because it does not explore parents' understanding of what they expected from the service.

Mc Intosh (1986), as part of a study of the transition to motherhood and practices of infant care, looked at the consumer perspective on the health visiting service. Sixty working class mothers were each interviewed on six occasions between the seventh month of pregnancy and about nine months after the birth of their first child. Women who participated in the study had little understanding of the role of the health visitor and saw her function mainly in terms of social control: policing of child abuse and neglect and the monitoring of maternal competence and the adequacy of the home environment. While many mothers in this study spoke warmly of their health visitor in terms of personal attributes, the professional role of the health visitor was described in negative terms. Personal experience of parenthood, informality and a non-authoritarian style of approach were the attributes valued by mothers, while most

reported that their health visitor used a more direct approach than they wanted and based their advice on theory rather than practice. Home visits were interpreted by many mothers as a means of surveillance, although it has to be noted that in this study almost all home visits were carried out unannounced, a practice rarely used today, certainly in the area where the present study took place. Also, most mothers in McIntosh's (1986) study had good family support and had previous experience of caring for children, which he found greatly diminished the number of problems encountered by them, with those lacking experience and support reporting substantially more problems than those who had this advantage. The main problems which mothers in McIntosh's (1986) study faced related to the social experience, and in particular, to their lifestyle, self-image and relationships with others. They were reluctant to expose these problems to the health visitor, as they saw her agenda as being focused on how the mother's negative feelings might affect her child, resulting in increased surveillance and the possibility of their child being removed, rather than support for themselves in their own right. McIntosh (1986) and Machen (1996) demonstrate how parents can associate the health visiting service in general, and home visiting in particular, with both surveillance and support. It is therefore important to explore what contributes to these opposing perceptions.

Weatherley (1988) carried out a survey of parents of 50 children from her own caseload about their views on the health visiting service. While parents were generally very happy with the health visiting service, Weatherley suggests that her findings demonstrate that some parents of second and subsequent children may not receive the attention they require, because health visitors automatically assume they do not require so much help as first-time parents; in fact, some parents may need help with second and subsequent children because individual children within one family can be very different in terms of approach required and problems presented. It is also likely that having more than one child presents the parents with increased stress and different problems such as sibling rivalry. She also draws attention to her finding that some parents who found the health visitor very approachable and the service as a whole very helpful still found it very difficult to discuss family worries with her. Some parents, asked to identify weaknesses in the service stated that they did not

really know what the health visitor's job entailed, which illustrates the problems associated with user satisfaction questionnaires. Weatherley suggests that the positive relationship between the approachability of the health visitor and satisfaction with the service as a whole corroborates Clark's (1984) finding that 'approachability' was the most commonly quoted characteristic of an ideal health visitor, even ahead of 'expertise.' The study is limited because of the likelihood of respondents wanting to give favourable feedback to their own health visitor. Also, as Weatherley acknowledges, the study's identification of parents' lack of understanding of the service negates the measurement of satisfaction with it.

Field et al. (1982), in a survey of 78 first-time mothers' views of the health visiting service in Cambridgeshire, found that while 60% of respondents were positive about the service, the other 40% were generally disappointed with it. Health visitors viewed positively were felt to be "friendly, approachable, ready to answer questions and to listen to problems, and quick to respond to pleas for help" (p300). A notable quality was her ability to boost the woman's confidence in herself as a mother. In contrast, health visitors disliked by the mothers in their care were often regarded as "interfering, authoritative, unsympathetic and out of touch" (p300). Criticisms were made of the limited availability of health visitors, and of clinics with queuing, lack of privacy and lack of continuity of care. Many of the women interviewed believed that health visitors should first and foremost be mothers themselves, and described in various ways how advice given by a health visitor who was also a mother 'rang true' whereas that given by a childless health visitor "could not be taken seriously" (p300). An association was found between contact with the health visitor in the antenatal period and the degree of support experienced afterwards in the postnatal period, which Field et al. (1982) propose is due to the relative ease with which a good health visitor-parent relationship can be established at this time. The study findings suggest that parents value health visitors' communication and confidence-building skills and personal experience of childcare more highly than professional knowledge.

Oakley (1981) describes the new parent as travelling "in a foreign country" and finding that communication of their experiences "is hindered by the gap between

mother and expert” (p308). She suggests that experts too rarely see experience as any sort of qualification, despite its important role in empirical testing of theory. Oakley’s study was conducted two decades ago and may not be relevant to contemporary health visiting.

Foxman et al. (1982), as part of a longitudinal survey of the experiences of first-time parents during the transition to parenthood (defined as from early pregnancy till a year after the birth), looked at the reaction of 85 mothers to the health visiting service in the first six weeks of their child’s life. While almost half the mothers were very satisfied with the service they had received, just under a quarter had mixed or negative feelings about it. The physical accessibility and the approachability of the health visitor were important to mothers, and the relaxed and informal atmosphere of home visits were contrasted with the institutional nature of the clinic. The study is limited because it is restricted to the very early days of parenthood, parents may not have known what they could expect from the service and the indices of satisfaction were determined by the researchers. However, as in Machen’s (1996) study, home visiting was associated with support rather than surveillance.

The literature relating to parents’ views of the health visiting service suggests that parents are not aware of the remit of the service and therefore are not able to make a valid assessment of the degree to which their needs are met. While some parents appear very satisfied with the service, it is often unclear whether it is the person or the service which is being applauded and what needs the parents have. Those critical of the service may be those whose needs are greater or those with a better understanding of the wider role of the health visiting service who therefore expect more from the service. While factors such as the socio-economic background of parents appear to affect parents’ satisfaction with the service and their understanding of the health visitor’s role in terms of support and surveillance, there appears to be a need to explore these facets in greater detail using qualitative methods.

3.7 The health visiting process in relation to families with young children

The review of the literature of users' perspectives of the health visiting service provides an insight into clients' understanding of some of the processes involved in health visiting interventions. The literature on health visiting is now developed further by concentrating on studies which set out to investigate the processes involved in health visiting. While all areas of nursing need to be explored and explained in terms of the processes involved in delivering care, perhaps health visiting has proved more difficult to research than, for example, district nursing in which the processes have been more obvious to both those who deliver and those who receive care, as well as to the general public. In the past, health visiting processes were measured in quantitative terms, by counting immunisation rates, attendance at child health clinics and numbers of home visits. It is only comparatively recently that qualitative methods have been used to elucidate the processes involved in health visiting interventions.

Luker and Chalmers (1990) carried out a study to explore the ways in which health visitors gain access to clients in order to carry out health promotion. Forty-five experienced health visitors were interviewed with a view to elucidating the ways in which health visiting practice is conceptualised and evaluated in everyday practice. Gaining access involved both being admitted to the client's environment (usually the client's home), and also gaining entry into a relationship which is conducive to successful health visiting intervention being accomplished. Three types of factors were found to affect the quality of the health visiting intervention: client factors, health visiting factors and other factors which came from the health visitor-client encounter.

Client factors which facilitated entry were when the intervention was requested by the client, when the client understood and valued the role of the health visitor and health promotion, and when the client had positive past experiences of health visitors. Parents would be expected to be more receptive to health visitors in these situations.

Health visitor factors related to being able to explain the reason for making contact, which was usually attributed to routine surveillance or to a referral from another agency such as the general practitioner. Health visitors also tried to focus on the client's agenda in order to be accepted, both at the time and in the future, and tried to adjust their approach to "hit the level" (p78) of the individual clients. Occasionally health visitors adopted an authoritarian approach to gain initial entry, even to the extent of suggesting, wrongly, that they had right of access. This strategy was used when the health visitor had concerns about the welfare of children, and other tactics were used once entry had been secured. Health visitors in this study appeared to see themselves in terms of surveillance of families.

Health visitors used various tactics when they found that access to clients was difficult, including temporary withdrawal, continued attempts to visit and carrying out only routine activities, such as developmental assessments which were considered relatively unobtrusive. Health visitors tried to break down barriers through the use of humour and by showing genuine concern for the family, suggesting that offering support was only a means to carrying out surveillance. The emphasis in this exploration of health visiting practice is on a traditional health visitor-client relationship, with the participating health visitors having an agenda which was only altered to address the client's perceived needs in order to gain compliance. The principles of marketing appear to apply to the encounters, health visitors wanting to be seen as offering a commodity of benefit to parents and parents looking for rewards of interest to themselves.

Chalmers (1994), in a related study, explored the process of health visiting in relation to difficult situations using the same interviews with 45 experienced health visitors as described earlier (see p73). Three types of difficult situation were identified: concerns about child care and safety because of poor parenting, inappropriate use of health visiting services, by clients either being too dependent on the service or rejecting the service (either outright or more subtly) and client denial and blocking, when clients would not acknowledge problems identified by the health visitor. These difficult situations were approached in several ways: carrying on in the

same way as before, waiting for a suitable opportunity to raise an issue, withdrawing from the situation, resorting to routine health visiting, looking for other approaches and confrontation. This study also emphasises the traditional health visitor-client relationship, with health visitors adopting strategies aimed at meeting the clients' needs as identified by the health visitors.

Chalmers (1992) used data from the same study (interviews with 45 experienced health visitors) to examine how experienced health visitors conceptualise and evaluate their health visiting work. The health visiting process was seen to consist of three phases: the entry phase, the health promotion phase and the termination phase. The entry phase involved gaining access to the client both physically and intellectually, and was enhanced by the client being aware of the reasons (as identified by the health visitor) for the involvement and being receptive to this. The health promotion phase was devoted to health visitors and clients working towards improving the client's health, with both client and health visitor controlling what they 'give' and 'receive' during encounters. Clients could decide how much information to share with the health visitor and how much advice to accept, while health visitors can regulate what they offer to clients and also which direct requests and subtle cues to respond to. The termination phase does not apply to parents with young children, although the formal contact with them usually stops when the child starts school. Chalmers suggests that health visitors may be more effective by functioning as a player in the 'game of give and take' rather than solely acting in a prescriptive role as directed by managers and policy makers. This analysis again reveals a very traditional approach to health visiting practice and there are implications of a power struggle between parents and health visitors.

Chalmers (1993), using the same data as above, involving interviews with 45 health visitors, investigated the ways in which health visitors conceptualise and search out need. The findings of this study suggested that searching out and raising awareness of health needs was a significant aspect of health visiting practice and involved four situations: when the needs were identified by the client, when they were obvious to the health visitor, when they were uncovered by the health visitor and when they

were suspected but hidden. Health visitors were found to use several processes to search out needs and raise clients' awareness of these needs. Asking questions helped health visitors to identify needs and also helped clients to become aware of these needs. Referring to examples of other clients, suggesting that certain feelings or actions were common, and in some cases talking about their own experiences was used to encourage clients to talk about their own situations. Health visitors also searched for needs while addressing concerns identified by the client and often responded to cues and used previous experience of similar situations to determine clients' needs; this involved the development of a 'sixth sense' by health visitors. Health visitors were inclined to identify needs for which resources were available and to ignore those they could not resolve themselves or by referring to another agency. The studies by Luker and Chalmers (1990) and by Chalmers (1992, 1993, 1994) involve only health visitors' perspectives and would be more valuable if the parents' understanding of the health visiting process had been investigated. The health visitors appeared to be using a very didactic approach which is contrary to current moves towards facilitating the empowerment of parents, for example by the Child Development Programme (Barker 1987) and controlled the interventions in terms of the identification and resolution of problems, using a parent-led approach only as a means of increasing compliance with their professional agenda.

Collinson and Cowley (1998) in their qualitative study of nine mothers' perspectives of need and demand for health visiting services, proposed that families have three levels of need. Using the analogy of an iceberg it is proposed that one level is exposed and involves concerns considered legitimate and usually child-oriented. The other two are submerged, the one near the surface containing needs which are usually relating to the mother and involving emotional problems, and which can be exposed by giving clients time and space. The deepest level contains needs of which the mother may not be aware herself, and which also may not be recognised by the health visitor. Collinson and Cowley (1998) suggest that both clients and health visitors may find it difficult to describe the two levels of need which are below the surface, and the role of the service in addressing these needs. The study findings suggest that working in partnership with parents might assist the exposure of deeper

needs and that level of need may correspond to parents' perceptions of the role of the service and of the health visitor's agenda. Deeper needs are also likely to be identified by a holistic analysis of parenthood and of the health visiting service, from the parents' perspectives.

Pearson (1991) explored the ways in which parents and health visitors identified and interpreted clients' health needs, how clients developed perceptions of the health visiting service and how these perceptions compared with those of health visitors. The study involved interviews with nineteen primiparous parents during pregnancy and when the baby was 8-10 weeks old and 7-8 months old, from which six case studies were chosen for further analysis, three from an area of deprivation. Ten of the health visitors involved with the families were also interviewed. The study was reported in two papers written by the author in 1991 and 1995. It was found that parents in the antenatal period were uncertain about the problems they were likely to face and the resources which would be at their disposal, but anticipated coping mainly by themselves with a little direction from professionals. Parents with previous experience had a more concrete understanding of potential problems and anticipated coping on their own with some assistance from more experienced family and friends.

In the early days of parenthood, professional help was seen as important, even by parents with previous experience, with a particular emphasis on differentiating between normal and abnormal problems. By the time of the third interview, parents were more self-confident and were more able to recognise normal problems which were of little significance. At this stage a more reciprocal relationship with professionals was sought and Pearson (1995) notes that sharing experiences with friends was seen by parents as important. Pearson found that while at the second stage there was agreement between parents and health visitors about the role of the latter, parents placed more emphasis on the relationship than did health visitors. At the third stage, health visitors saw their role diminishing because parents were usually experiencing few problems. Pearson (1995) suggests that this was because health visitors focused on the child's development, while parents were concerned with the social and emotional aspects of health. At this stage Pearson (1995) notes

that health visitors saw their role as monitoring while parents wanted more support. Pearson (1991) proposes a substantive theory based on three strands of the health visitor-client interaction: the development of the parent as a parent, the development of the child and the development of the health visitor-client relationship. The study highlights the importance of looking at the perspectives of parents when planning interventions and of making clear to parents what the health visiting service can offer them.

The health visiting process was explored by Kendall (1993) in relation to the extent to which clients participate in health visiting interactions, by analysing 62 tape recorded health visiting interventions with parents of young children. She found that health visitors were largely in control of the conversations by setting the agenda, giving unsolicited advice and bringing the conversation to an end. Kendall proposes that rather than playing out a prescriptive role and running the risk that their services will be at best, tolerated and perhaps rejected, "being able to suspend or amend the 'script' of their professional role and function more as a player in the 'game of give and take,' health visitors may be able to provide a service which clients find helpful and acceptable" (p1323). This, according to Kendall, might enhance health visitors' influence on clients' health. Kendall's recommendations appear to encourage the imbalance of power between health visitors and parents which is so evident in her study, rather than advocating starting from the perspectives of parents and working in partnership with them as advocated by Twinn (1993).

Cowley (1995), using data from interviews with 53 health visitors, proposes that health visitors have difficulty in explaining their role because of the uncertainty and ambiguity which surrounds health visiting practice. She suggests that working with no well-defined objectives goes against many of the established principles of nursing. Underlying this uncertainty is health visitors' awareness of their service usually being unsolicited by clients, and therefore in some cases not needed or wanted by clients. They are also sometimes conscious of clients having a more pressing agenda than that of the health visitor. Findings from this study again point to tensions

between professionally determined problems and solutions and the concerns of clients.

de la Cuesta (1993) used interviews with 21 health visitors and 41 days of participant observation in clients' home and clinics, with a sample chosen to represent a diversity of socio-economic backgrounds and health visiting experience, to gain an insight into the processes of health visiting. de la Cuesta proposes that health visitors are a bridge between the 'policy' world and the 'people' world, and uses the term "fringe work" to describe activities undertaken by health visitors which are not part of the policy agenda. In the study she found that different health visitors had different definitions of fringe activities depending on their understanding of what constitutes 'true' health visiting practice. Some fringe activities were described in terms of being done covertly, not being recorded or acknowledged openly, such as giving clothes to clients. Others were activities not regarded as core work, such as setting up innovative projects, which could be recognised as core work once established. In some cases the reverse was demonstrated: health visitors carried on with activities which were no longer core work or started carrying out an activity again which was no longer official policy. Fringe work often involved "backstage activities" such as writing letters on behalf of clients, which de la Cuesta refers to as "the 'bureaucracy' of fringe work" (p607).

Some types of fringe work involved interventions which were not provided by other agencies and not strictly the province of health visiting practice, but were considered important to the family's well being, such as writing letters to housing departments. Others were more to do with meeting the client's agenda in order to increase the chances of them complying with the official aims of the health visiting service, such as giving free samples of baby food. Health visitors working in deprived areas sometimes described much of their work as fringe because of the overlap with the role of social workers. Fringe work appears to involve responding to needs defined by health visitors rather than by management, and by clients, but in this case only to increase the clients' compliance with professionally identified activities.

de la Cuesta (1994a), using data from the same study, uses marketing terms to describe the health visiting process. According to de la Cuesta, health visitors promote the service, by raising clients' awareness of their need for it, by selling themselves (by adjusting their approach for individual clients), and displaying the service, for example, by showing parents charts and records. They adjust delivery of the service by bargaining, for example the time of the next contact, timing interventions to maximise the chance of clients' compliance and pacing interventions to suit the clients' receptivity. Finally, health visitors tailor the service to individual clients by arranging the agenda to respond to clients' perceived need, by negotiating and compromising and by undertaking 'fringe' work as described above. This study is very explicit about the way that the author interprets health visiting in terms of manipulation of clients.

Cowley (1991), in a qualitative study involving interviews with 53 health visitors, found that "tuning in to," "getting to know" and "establishing a relationship with" clients were important aspects of health visiting practice, as was "getting known." Thus a sense of trust was established with clients, which facilitated the disclosure of concerns by clients, again with the aim of achieving professionally identified goals.

Kristjanson and Chalmers (1991) propose that working at the macro level and becoming involved in community development work would be a better way of addressing health issues, and also call for contracts to be drawn up with clients in order that problems can be mutually identified, interventions and goals planned in partnership, and expectations of health visitors and clients made clear. This would be likely to reduce what appears to be manipulation of clients by health visitors and the often clandestine resistance of clients to health visiting interventions. The present study aims to examine how parents perceive their experience of the health visiting service in terms of meeting their own and professional agendas and to identify parents' perceptions of any conflicts between them.

3.8 Vulnerability

The previous chapter identifies some of the difficulties which the literature review suggests are associated with being the parent of a young child. The literature on health visiting reviewed so far highlights how health visitors identify needs which do not conform to managerially determined goals. The literature about the ways in which health visitors conceptualise need and identify vulnerable families is now addressed.

In a study to investigate how health visitors reach decisions on a family's vulnerability in relation to child abuse, involving a postal questionnaire to 102 health visitors and in-depth interviews with twelve of the respondents, Appleton (1995) found that health visitors often identified families as being vulnerable who did not meet the health trust's criteria of what constitutes vulnerability. Appleton (1994), in an analysis of the same study, found that health visitors were conceptualising vulnerability in terms of stress, coping ability and levels of support available to the family. Stress was described as internal or external, and lack of social support was highlighted by many health visitors as a major source of vulnerability. Health visitors who participated in Williams' (1997) qualitative study of how health visitors plan and organise their work in relation to the concept of vulnerability, also recognised social isolation as being a major contributing factor to vulnerability in families living in deprivation and also those living in relative affluence. The study involved two small focus groups and seven semi-structured interviews with health visitors from two contrasting areas, one inner city and the other suburban. While health visitors working in an area of deprivation talked about the effects of poverty and deprivation on parents' ability to cope, health visitors working with professional families tended to discuss the outcome of family stress in terms of post-natal depression, and problems dealing with children usually in connection with feeding and sleeping. Health visitors from both areas assessed families' vulnerability in relation to factors such as parents' self-esteem and coping skills, and the expectations and involvement of fathers.

The differences between managerial and practitioners' understanding of vulnerability provides further evidence of the confusion which seems to surround the assessment of families and the planning and delivery of health visiting interventions. The present study looks at parents' vulnerability from their perspectives by analysing parents' experience of their role.

3.9 The health visitor-parent relationship

The literature reviewed so far suggests that the relationship between individual health visitors and parents has a profound effect on the effectiveness of interventions with families, and that a good relationship often seems to dispel parents' negative image of the service. Parents' emphasis on approachability in judging their health visitor also points to the importance of the health visitor-parent relationship. The chapter therefore ends with a review of the literature on professional-client relationships in health visiting and in a wider context.

Chalmers and Luker (1991) explored health visitors' perspectives of the health visitor-client relationship in relation to families with young children using data from the study described earlier (see p69), involving interviews with 45 health visitors. Health visitors believed that being seen as helpful by clients was the most influential factor in establishing a good relationship with clients. Showing respect and genuine concern was also considered important for establishing and maintaining a good relationship, especially in the early days. A positive relationship facilitated disclosure of problems such as relationship difficulties with partners following the birth of a baby and long-standing problems including past experience of abuse. Health visitors felt they could reduce contact with clients with whom they felt they had good rapport because they believed they could assume that these clients would approach them if they required help. As discussed previously, health visitors in this study seemed to be using their relationship with clients as a means of manipulating them to comply with their professional agenda rather than as a therapeutic intervention.

de la Cuesta (1994b) using data from the study described earlier (see p79), described the health visitor-client relationship as a resource which is required in order to learn

about client and family, to gain and maintain access to clients and to facilitate a two-way exchange of information and to gain compliance from clients. Showing care and concern were seen by health visitors as one way of increasing compliance, as were other favours such as giving lifts to hospital appointments and providing forms and information which could be useful to the client. de la Cuesta found that health visitors gave accounts which highlighted their dual role as professionals and friends, clients volunteering information to the health visitor in the friend role which was then used to make professional judgements and decisions. Building up a good relationship is therefore seen as a means of achieving goals in terms of compliance, rather than as a beneficial intervention in its own right. This manipulation of clients may be interpreted as representing an abuse of power by health visitors and appears likely to result in disempowerment of parents. However, the role health visitors have in detecting child abuse and neglect may justify this approach to health visiting practice as it may be seen as a means of gaining information about families which could enhance the safety of children.

The health visitor-parent relationship receives little attention in the literature, especially as seen from the perspectives of parents. Dobson (1989) proposes that reciprocity is central to the health visitor-client relationship, but also suggests that this concept has been given little attention because the emphasis has been on the health visitor stages rather than the client stages. Chalmer's (1992) discussion of 'give and take' in health visiting interventions (see p75) relates only to information and does not address other areas such as support. There appears, therefore, to be a need to explore this aspect of the health visiting process.

Robinson (1996) in a grounded theory study designed to explore the process and outcomes of nursing care, found that health care relationships were pivotal to change. Five families who were experiencing difficulty managing a member's chronic illness were interviewed and all families were very positive about the nursing care they had received. However, all families emphasised the relationship with the nurse rather than "what nurses would call interventions" (p152) as being the most important contribution to the care received. Interventions which made a significant difference

were primarily those that promoted and enhanced particular relationships: among family members and between the family and the nurse. The skilled nurse was found to be curious listener, compassionate stranger, nonjudgemental collaborator and mirror for family strengths. By listening and asking good questions, having a balance between closeness and distance with the family, working in partnership and accepting family values, and making families aware of their strengths, nurses helped families to cope with difficult situations. These aspects of the nurse-family relationship were considered to be effective in their own right, rather than as a background to other interventions. While this study relates to families caring for a member with a chronic illness, the same qualities are likely to be important for health visitors working with families experiencing parenting difficulties. Also, even when health visitors claim to be using their relationship with parents as a means of achieving managerially driven goals, the parents may derive benefits from the social support such as increased self-esteem.

Morse (1991), from interviews with 44 nurses working in a variety of settings, describes four types of mutual nurse-patient relationships which she believes to depend on the duration of the contact between nurse and patient, the needs of the patient, the commitment of the nurse and the patient's willingness to trust the nurse. Clinical relationships are a feature of short contacts for minor conditions with little personal emotional involvement, while therapeutic relationships exist when the nurse views the patient mainly in the patient role, with psychosocial needs being met by family and friends, except those specifically evolving from the patient role such as anxiety about surgery. In connected relationships the nurse views the patient first as a person and second as a patient, while maintaining a professional relationship, with both patient and nurse investing some effort into the relationship. An over-involved relationship occurs when the relationship goes beyond the professional nurse-patient boundaries, with the nurse seeing the patient only as a person and having contact outside working hours or being prepared to carry out tasks outwith those associated with the professional nursing role. Patients were found to assess nurses by three criteria: their personal circumstances, their performance as nurses and their trustworthiness. Nurses were found to assess patients in relation to their personal

needs and support systems and as people; they tried to build a relationship with patients by sharing personal information and by the use of humour. Both nurses and patients could control their level of involvement and sometimes there was asynchrony between nurse and patient with one wanting more involvement than the other. However, as might be expected, relationships were more involved in care settings such as palliative care and more superficial in areas such as accident and emergency and intensive care. It therefore appears relevant to look at the parent-health visitor relationship from the parents' perspectives, in the context of how families function and the other sources of support available to them.

Nursing theories concerned with how nurses interact with patients were formulated in the 1950s and 1960s. Peplau (1952) focused on interpersonal relationships and processes, including the nurse-client relationship, communication, pattern integration and the roles of the nurse. While Peplau based her theory on psychiatric hospital-based nursing, the same principles can be applied to health visiting, the obvious differences being that health visiting concerns itself with health promotion and usually involves a long-term relationship with clients. The nurse-client relationship starts with the orientation phase where the nurse and client get to know one another and the client begins to trust the nurse. Next comes the working phase when the client begins to identify problems and makes use of the nurse to solve them. According to Peplau, the nurse does not solve the client's problems or give direct advice, but provides the client with the opportunity to explore options and opportunities by providing information. There then follows the resolution phase when the client may be helped to use community resources, to strengthen social supports and to reflect on the nursing intervention. Peplau (1964) considered the relationship between nurses and patients an important aspect in the solution of health problems, but differentiated the professional relationship from the social one. She described the use of self as a resource which the nurse can use to achieve a professional goal. Peplau (1988) portrays the nurse as enacting several roles, for example, resource person, teacher, surrogate for significant other, counsellor and technical expert. In terms of health visiting, these roles could be found within an extended family and it is therefore relevant to ascertain whether health visitors are

perceived as substituting for roles which might traditionally have been undertaken by the family's network of family and friends.

3.10 Caring, supporting and therapeutic use of self in health visiting practice

It has been shown that in the literature relating to the process of health visiting, considerable attention has been given to the importance of the health visitor-client relationship, and to the role of the health visitor in providing parents with support, often conceptualised as a fringe, rather than mainstream, activity. Squier (1990) expresses concern that practitioner-client relationships are not accorded more priority alongside technological advances, and suggests that practitioners cannot tease out the processes in their relationships which are therapeutic. Health visitors who participate in research studies may tend to play down any importance they attach to their relationships with parents because they feel unable to explain the significance they attach to them. While the present study does not set out to examine health visitors' perspectives on their role in relation to families, it does explore how parents perceive the significance of the relationship they have with health visitors regardless of whether health visitors see this as important per se or as a means to achieving other goals. The literature relating to caring and other related aspects of nursing practice and their importance as interventions in their own right, rather than as a means to achieving other goals, are now explored.

Caring has been established as the central focus of nursing practice (Leininger 1988, Benner and Wrubel 1989). Benner (1984) portrays caring as an interactive experience between the client and the nurse which changes in response to the context of the interaction and involves a kaleidoscope of closeness and distance in both dramatic and mundane periods of people's lives. Many of the nursing theories which have been developed have used caring as a core concept. Leininger's Theory of Culture Care is based on the tenet that "care is the essence of nursing and the central, dominant, and unifying focus of nursing" (Leininger 1991, p35) and that care has to be tailored to suit clients' cultural beliefs, norms and lifestyles. Watson's Theory of Human Care centres on helping people to gain a higher degree of harmony within the

mind, body and soul, which she believes is achieved through caring transactions (Watson 1985).

Cowley (1995), in a grounded theory study of the practice of 53 health visitors, suggests that there are two aspects of health visiting interventions: caring and education. Education often involved raising clients' consciousness, which Cowley (1995) compares with the health visiting principle 'stimulating awareness of health needs' (CETHV 1977), and working with clients to develop their own resources to meet these needs. Caring activities involved making time for clients and supporting them in times of difficulty. Caring was perceived as a way of preventing a deterioration of health. Cowley highlights the tensions which arise between the organisationally-defined definitions of health-enhancing activities which depend on firm boundaries, and health visiting interventions in which boundaries blurred and the focus changes constantly because of the holistic approach adopted by practitioners. In this study it was found that:

"there was a widespread impression in the data that these close, caring and personal links needed to be forged and maintained covertly: they were generally not described as part of the 'work' which health visitors felt was expected of them by their employers." (p440)

Cowley links this finding with those of other studies in which health visiting clients view health visiting negatively, but describe their own health visitor in very positive terms. Cowley sees this caring aspect of health visiting, which is recognised as being of importance in health promotion, as being linked to the nursing aspect of health visiting, although some of the health visitors in the study believed that this was not a legitimate part of their role. There appears to be confusion about the role of caring in health visiting. There is ambiguity about whether this is an activity in its own right or whether it is a means of manipulating clients in order to achieve professionally defined goals.

Campbell (1984) uses the term "skilled companion" to describe the relationship between the paid health professional and client. Companionship has less intense

connotations than caring, and also suggests some movement and limits to the relationship and to the time devoted to the role, according to Campbell.

Watson (1985) identifies humanistic caring as the ethic that undergirds nursing activity and the values and assumptions of her nursing model. Nursing activity is focused on intersubjective human-to-human contact, which is the medium for transpersonal caring. The nurse uses herself to engage in a genuine, unique transpersonal relationship with another human being. The development of a trusting relationship, involving genuineness, non-possessive warmth and empathy, and effective communication between the nurse and client, is seen as essential for transpersonal caring.

Leininger's theory of transcultural care derives from the disciplines of nursing and anthropology. Emphasis is given to people's historical, social and cultural context in order to improve and advance the quality of their care through the deliberate and creative use of transcultural nursing knowledge which that reflects culturally congruent care based on the values, beliefs and lifestyles of people from different backgrounds. For Leininger (1991), care is the essence of nursing, and culturally based care can be predicted to promote health and well-being. Care is believed to have the greatest potential for explaining nursing phenomena and for predicting outcomes of individuals, families, groups and communities.

While the concept of caring in nursing has been acknowledged for half a century, the lack of recognition of the "fringe" activities in health visiting has resulted in caring roles in health visiting practice being ignored. The need for this caring role is not surprising in view of the review of the literature on parenting, which exposes parents' lack of experience and family support in caring for children. There appears to be a need to explore the nature of the health visitor-parent relationship, and the effect of this on parents' perceptions of the health visiting process. The history of health visiting, outlined earlier in this chapter, and with an emphasis on medically driven goals, also provides a rationale for the lack of recognition of the importance of caring as an activity in its own right in health visiting practice.

3.1 Summary and discussion

The evolution of health visiting in response to emerging public health concerns has been outlined. The difficulties associated with professional involvement in the private sphere of family life have been highlighted; these tensions have been shown to be mirrored by parents' understanding of the health visiting service as having a role in both surveillance and support of families. Parents appear to associate the surveillance role of the health visiting service with the health visiting service as an agency rather than with individual practitioners with whom they have had contact. Likewise, provision of support is more likely to be seen as being provided by individual health visitors than by the service as an entity. The relationship appears to be the cornerstone of successful health visiting interventions. Health visitors may pace their involvement with families in order to reduce resistance and optimise families' receptivity to the service. However the rate of progress depends on the perceived urgency to engage with families to address concerns about children's health and welfare. Both parents and health visitors appear ambiguous about the official role of the health visiting service and whether some activities which both parents and health visitors believe will enhance family functioning are legitimate or are 'fringe' activities. Caring appears to be an important aspect of the health visiting process, but is not generally recognised as a component of health visiting practice in its own right, even by health visitors. There is little evidence of theory being used to explain and develop health visiting practice, especially aspects concerned with caring.

The review of the literature suggests that parents are not really aware of the remit of the health visiting service and therefore are unable to make a valid assessment of the extent to which it meets their needs. This is not surprising in view of health visitors' own ambiguity about their remit in terms of 'official' and 'fringe' activities. Many of the studies of parents' satisfaction with the health visiting service are surveys which do not permit the exploration of parents' concerns and of the ways in which the service does and could meet them. Also, the studies reviewed do not place parents' views of the health visiting service within the context of parents' experience of their role and of the other influences and sources of advice and support. It

therefore appears timely to look at parents' views of the health visiting service within the context of contemporary family life to try to understand what role health visitors do and should have in helping parents to bring up their children.

Most studies of health visiting identify a very traditional model of practice with health visitors carrying out interventions with parents using a professionally driven agenda based on surveillance and a didactic approach to health promotion. Offering support and addressing parents' self-identified needs is portrayed by health visitors in many studies as being of importance only in relation to increasing parents' compliance with managerially determined goals, rather than as worthwhile activities in their own right. It can be argued that the principles of health visiting (CETHV 1977) and also policy-led agendas do not accord with a fully parent-centred approach to health visiting practice as it is the responsibility of health visitors to discern needs and to raise parents' awareness of these needs and the professionally determined actions required to address them, even when parents are not concerned themselves. These factors seem likely to provoke resistance by parents, especially if their self-determined needs are ignored or if parents realise these needs are only being addressed in order to create a sense of obligation to comply with professional goals which do not concur with those of parents. Health visitors might also be expected to relegate activities not complying with managerial and policy-related agendas to 'fringe' status. McIntosh's (1986) study suggests that parents are perhaps more in control of interventions than is suggested by studies involving interviews with health visitors; this heightens the sense of the health visitor-parent relationship involving a power struggle rather than partnership.

While Cowley (1995) identifies caring as an important health visiting activity in its own right, other qualitative studies involving health visitors as participants suggest that the caring aspect of interventions is only a means to fulfilling other aims and is a means of manipulating clients by creating a feeling of obligation. However, in view of the lack of recognition of caring as a worthwhile aspect of practice, it may be that health visitors are reluctant to describe this as 'official' health visiting practice especially in view of the medically oriented goals laid down by managers. The

present study is therefore concerned with analysing parents' understanding of health visiting interventions in terms of surveillance and support, and in terms of caring and control, all types of approach which are discussed in the literature.

The previous chapter demonstrated how parenting has evolved in response to social change. Health visitors are also likely to require to change their practice with parents of young children in response to changes both in family structure and function and also in attitudes to children and childrearing as outlined in Chapter 2.

Consideration of the literature about parenthood and health visiting suggests that it is important to explore the way parents perceive their experience of the health visiting service in terms of contemporary parenthood and the other sources of help and advice available to them, and also in terms of support and surveillance, and the parent-health visitor relationship.

CHAPTER 4: THE RESEARCH APPROACH AND METHODS

4.1 The purpose and focus of the study

This study attempts to provide an interpretive account and understanding of the experience of being a parent of a young child in contemporary times in Britain, and seeks to describe the health visiting process in relation to working with families with young children. This chapter describes the way in which I attempted to achieve this.

4.2 The purpose of the study

The purpose of the study was twofold. Firstly, I set out to try to gain an understanding of what it is like to be the parent of a young child in today's society, and then went on to explore the role of the health visiting service in the lives of families with young children.

Two research questions were addressed during the study:

- What is the experience of being a parent in contemporary society?
- What role does the health visiting service play in the lives of parents?

4.3 Justification for the research approach to the study

The challenge inherent in the aims of the study is to provide a thorough understanding of parents' perspectives of their experience of their role as parents and of the health visiting service.

Hermeneutic phenomenology, as a methodology, respects the capacity of those whose 'lived experience' is being researched for self-knowing. According to Koch (1995):

“Understanding occurs through a fusion of horizons, which is a dialectic between the pre-understandings of the research process, the interpretative framework and the sources of information. The implication for hermeneutic enquiry is that research participants are also giving their self-interpreted constructions of their situation. (p835)

Hermeneutics is not considered to be a special process but one of the processes people use in making sense of their everyday world. Hermeneutical analysis of the phenomenological description seeks to explicate an understanding of human behaviours and actions over and above the initial impression of the text (Allen and Jensen 1990). While all qualitative research requires a dialogical relationship between researcher and the researched, the phenomenological interview is reflective (Munhall and Oiler-Boyd 1993), with the researcher viewed as an important part of the research process. Heidegger (1962) argues that it is only possible to interpret something by reference to one's own lived experience. The interview is considered the main method of data collection in phenomenological research as it allows participants' descriptions to be illuminated, explored and gently probed (Kvale 1996). Hermeneutic phenomenology facilitates greater understanding of an experience while maintaining the context of the everyday lived experience where meaning resides. A hermeneutic approach for nursing research is recommended by Reeder (1985) because it places lived experience before understanding and promotes the illumination of nursing questions, and by Draper (1991) as a means of developing a pragmatic knowledge base for nursing.

My decision to use hermeneutic phenomenology was informed by a consideration of the literature on this approach and also on parenthood and the health visiting service. There appeared to be few recent studies of the experience of parenthood, and most concentrated on specific aspects such as dual-earner families (e.g. Brannen and Moss 1991, see Chapter 2:6 p23) and early stages of parenthood (e.g. Barclay et al. 1996, see Chapter 2.5: p19). There have been few studies carried out recently to examine contemporary parenthood and to build on the earlier research conducted by sociologists such as Oakley (1980), Boulton (1983) and Backett (1982) (see Chapter 2.5 pp20-21 and 2.7 p28). The study's aim of exploring the experience of contemporary parenthood suggested that hermeneutic phenomenology would enhance the understanding of parenthood by promoting the interpretation of parents' accounts of aspects of their lives within the context of the total everyday experience of their role.

The need to include users in determining health care policy and approaches to health care delivery, and the problems associated with understanding users' perspectives (see Chapter 3.5 pp64-66), also pointed to hermeneutic phenomenology as a suitable methodology. Studies of parents' views of the health visiting service reviewed in Chapter 3, such as those by Machen (1996) (see Chapter 3.6 p69) and Collinson and Cowley (1998) (see Chapter 3.7 p76), do not contextualise their views within their total experience of parenthood. Studies which explored the health visiting process in relation to families, for example Luker and Chalmers (see Chapter 3.7 p73) also did not relate the process to the lived experience of parenthood, and relied on health visitors' perceptions of the process rather than that of parents. de la Cuesta's (1993) "fringe activities" appeared to be associated with aspects of parenting unofficially recognised by professionals (see Chapter 3.7 p79), while Cowley's (1991) reference to the need for health visitors to "tune in" to parents (see Chapter 3.7 p80) implies that health visitors need to take heed of parents' experience of their role in carrying out successful interventions with parents. Also the review of the literature pertaining to vulnerability (see Chapter 3.8 pp81-82) suggests that an interpretation of the experience of parents is required to fully illuminate the factors which contribute to the vulnerability of families.

As an experienced health visitor I realised that while it was important to reflect on the understanding and biases I brought to the study, it was impossible to 'bracket' these from the research process and that they would inevitably affect the framing of the research questions, the data collection and analysis and the interpretation of the findings. This led to my decision to use a Gadamerian approach, which acknowledges the influence of the researcher on the study.

Hermeneutic phenomenology thus appeared to provide the best method of interpreting the everyday life of parents and the role of the health visiting service in parents' lives.

4.4 Introduction to the methods used in the study

The case for qualitative research approaches has already been convincingly demonstrated, not only in social science in general but in nursing in particular.

Qualitative inquiry is not a single approach with a singular subject matter. Jacob (1988) has observed that the effort to differentiate the qualitative/ naturalistic (holistic-inductive) paradigm from the quantitative/ experimental (logical-deductive) paradigm created the impression that there are only two methodological alternatives.

All of the major social sciences have drawn on and contributed to qualitative methods, but each in a somewhat different way depending on the theoretical interests of a particular discipline (Kuhns and Martorana 1982). The methods appropriate in a qualitative study depend on the questions being asked. Nursing research draws on theory from many branches of the social sciences, particularly psychology and sociology, as well as having a body of knowledge specific to nursing, pioneered by nursing theorists such as Peplau (1952) and King (1971). Levi-Strauss (1966) describes the multiple methodologies of qualitative research as *bricolage*, and the researcher as *bricoleur*, a 'Jack of all trades.' The qualitative researcher-as-*bricoleur* uses the tools of his or her methodological trade, deploying whatever strategies, methods or empirical materials as are at hand (Becker 1989).

Concern for theory development is often quite marked in the literature on qualitative methods. The writings of many well-known qualitative methodologists, such as Glaser and Strauss (1967), Denzin (1978), Lofland and Lofland (1984), and Becker (1970), take as a major focus the task of theory construction and verification. While much of the discussion about theory development centres on the emphasis on inductive strategies in contrast to theory generated by logical deduction from a priori assumptions, the approaches which use qualitative methods to stay grounded in the empirical world vary considerably in their conceptualisations of what is important to ask and consider in elucidating and understanding the empirical world.

4.5 Approaches used in this study

Interpretive approaches

Interpretivism is essentially about contextualised meaning. In interpretivism, the aim is to make sense of social reality, “based on a constant process of interpretation and reinterpretation of the intentional, meaningful behaviour of people -including researchers” (Smith 1989 p85). According to Smith (1989), “truth is ultimately a matter of socially and historically conditioned agreement” (p73). Reality resides neither with an objective external world nor with the subjective mind of the knower, but within interactions between the two (Barone 1992b). Social enquiry therefore is mind dependent; inquiry descriptions and interpretations are themselves constructions and (re)interpretations; and there can be no separation of the investigator from the investigated (Smith 1989).

Greene (1998) proposes that “what is important to know, what constitutes an appropriate and legitimate focus for social inquiry, is the phenomenological meaningfulness of lived experience - people’s interpretations and sense makings of their experiences in a given context” (p384). Thus parents’ reflections of their experience of bringing up children and of the role of the health visitor in this process involve their own interpretations of these phenomena and the way in which they understand them. This process is inevitably hermeneutic, because “investigators, like everyone else, are part of the of the circle of interpretation” (Smith 1989 p136). Researchers thus add their own interpretation and understanding to that of the researched. In the present study, the ‘truth’ of parents’ experience of parenthood and of the health visiting service was inevitably affected by the meanings given to these experiences by the parents and by myself. My own understanding of the data was likely to be guided to some degree by my previous experience of health visiting with the close consideration of family functioning which is involved in health visiting practice. Other experiences, such as my personal experience of family life, as a child and as a wife and mother, must also have had some bearing on my interpretation of participants’ accounts. So understanding meaning as the goal of interpretivist enquiry

“is not a matter of manipulation and control, particularly via method, but rather it is a question of openness and dialogue” (Smith 1989 p137).

Hermeneutics

The word hermeneutics is derived from the Greek word *hermeneia* and refers to a Greek technique for interpreting legends, stories and other texts. To make sense of and interpret a text, it is important to know what the author wanted us to know, to understand meanings as intended by the author and to place documents in a historical and cultural context (Patton 1990).

Gadamer (1987) states that:

“Hermeneutics has to do with a theoretical attitude toward the practice of interpretation, the interpretation of texts, but also to the relation to the experiences interpreted in them and in our communicatively unfolded orientations of the world.” (p324)

Benner (1985) describes hermeneutics as a systematic approach to interpreting a text. The interpretation entails a systematic analysis of the whole text, a systematic analysis of parts of the text, and a comparison of the two interpretations for conflicts and for understanding the whole in relation to the parts, and vice versa. Whole cases can be compared with other whole cases. Usually, this shifting back and forth between the parts and the whole reveals new themes, new issues, and new questions that are generated in the process of understanding the text itself. Thus, for example, parents’ attitudes to disciplining their child can be examined as a separate phenomenon, in relation to parents’ perceptions of their own experience of discipline as a child and also in the context of all the other relevant factors revealed by parents. Benner (1985) suggests that while the participants offer a depiction of the lived experience, the interpreter’s distance and perspective is used to understand the immediacy of the lived situation. These experience-distance perspectives must also take into account the person *in* the situation.

Phenomenology

Phenomenology, by the nature of the word, means the study of phenomena.

The work of Martin Heidegger (1889-1976), who is considered the prime instigator of modern hermeneutics, arose from the work of the phenomenologist Edmund Husserl (1859-1938) under whom Heidegger studied in the first quarter of the century. Husserl sought to establish a science of phenomena as a science of the cognition of *essences* rather than of matters of fact. He classified this phenomenology as *transcendental*.

Therefore, rather than the ontological differentiation between 'real and unreal' Husserl distinguishes between 'fact and essence' and his phenomenology encompassed notions of *pure consciousness*. Husserl suggested that researchers should 'bracket' the natural world in an attempt to suspend the 'naive realist awareness' of the researcher prior to data collection (Bartjes 1991). The work of Heidegger brought about a major shift in phenomenology, leading to the evolution of a second branch, hermeneutic phenomenology, with quite different emphases from Husserlian phenomenology. Heidegger moved away from the epistemological emphasis of Husserl to an emphasis on the ontological foundations of the understanding which is reached through "being in the world" and thus to what is postulated as the pivotal notion of human existence: *dasein*, a German word with no exact English counterpart. *Dasein*, a concept of the situated meaning of a human in the world, introduced a new understanding of what it is to be human, and can refer to a single person or to a general way of being. The notion of *temporality*, viewed as a connectedness rather than as linear time, is a strong theme in Heidegger's hermeneutics. Additionally, the *Dasein* concept of "being in the world" necessitates a view that the person and the world are *co-constituted*, this being an indissoluble entity (Koch 1995). As such, man makes sense of his world from within his existence and not while detached from it.

Packer (1985) states that according to Heidegger's view:

"we understand human action - and act ourselves - within a background of practices (bodily, personal and cultural) that is always present, although it can never be made fully explicit" (p1083).

Hermeneutic phenomenology

Hermeneutic phenomenology is holistic in that it seeks to study the person in the situation, rather than isolating person variables and situation variables and then trying to put them back together (Taylor 1987). Underlying all interpretation-laden practices and self-understanding that are handed down through language and culture is the notion of the 'background' which individuals cannot make fully explicit and cannot get completely clear about or clear of (Benner 1985). It is this background that makes human beings different from the artificial intelligence of the computer that always has to build its story up element by element, whereas human beings always come to a situation with a story, a preunderstanding. This position assumes that background meanings, skills, and practices are not completely rationalisable (cannot be made completely explicit), that this background forms the conditions of possibility, and that the background is handed down and not individually derived.

In hermeneutic phenomenology, the person is studied in the situation and pragmatic involved activity is considered as a way of knowing and being. Dreyfus calls this "embodied intelligence" (Dreyfus 1979). Dreyfus argues that in studying pragmatic activities and human concerns, an approach to theorising that is dependent on identifying decontextualised features *by definition* leaves out the meaning of the situation or situational understanding. Koch (1995) suggests that, according to Heidegger "the interpreter inevitably brings certain background expectations and frames of meaning to bear in the act of understanding. These cannot be ignored, forgotten or bracketed" (p832). Gadamer (1976) refers to the interface between the perspectives of the researcher and the researched as the "fusion of horizons." Koch (1995) suggests that there is no such thing as "uninterpreted observation" (p833), and that Gadamer "rehabilitates the notion of prejudice" (p833) by arguing that the researcher's pre-understanding makes the research meaningful for its consumers rather than getting in the way. As recommended by Koch (1996) a reflexive diary was kept during the research process to reflect on the development of concepts; this helped to identify prejudices. For example, when it became evident that the management of children's behaviour was a matter of concern for many parents, I was

reminded of situations in my professional practice when parents appeared to show little understanding of the need to set boundaries for young children resulting in difficulties in establishing and maintaining harmonious parent-child relationships. I realised that this may have exaggerated the importance of this aspect of parenting to me more than might have been the case for a researcher from a different background. Heidegger (1962) refers to the “hermeneutic circle” which involves the interrelationship of the whole, which defines and gives meaning to the individual parts, and through the parts, which together form and give meaning to the whole. Gadamer, who places a stronger emphasis on language than Heidegger, claims that language and history supply the shared sphere in the hermeneutic circle, leading Bleicher (1980) to assert that “the hermeneutic circle cannot be avoided, rather it is a matter of getting into it properly” (p103).

Hermeneutic phenomenology and the exploration of the health visiting process

Research in health promotion, including health visiting, often characterises health and health promotion, and providers and receivers of care, by sets of dimensions, correlates, concepts, and independent and dependent variables that are or can be fitted into models and theories of health and health promotion. These approaches remove subjects from the context of the situation and attempt to characterise them by a set of objective properties. The meaning of the life world of the person or family, their lived experience, their concerns and what matters to them are left out of the picture. These contextual issues constitute significance in families’ lives and in how they participate in health care situations.

Hermeneutic phenomenology provides health visiting with a theoretical basis for conducting research which does not reduce issues of concern to mere characteristics, absolute properties, or brute data (Taylor 1987). It is an appropriate methodology because it facilitates the understanding of the significance of practical activities in our everyday lives. The underlying assumption is that it is in the everyday practical activities of families and their members that the significance of health for the family can be uncovered and thus understood. The question of significance of health and health activities and practices for families is important in the planning and delivery

of the health visiting service. Exploration of individual facets of parenthood and parents' perceptions of the health visiting process facilitated an understanding of the total experience of parenthood, while the contextual factors assisted in the interpretation of particular aspects of the study.

4.6 The approach to data collection

Data collection consisted of focus groups and interviews with parents of young children, as part of a larger study which also involved the administration of a questionnaire, referred to in Appendix 3. The focus groups were carried out first, to identify and explore broad issues which formed the basis of the interviews. Both focus groups and interview data were considered to be of equal importance, with each having merits and disadvantages. Issues relating to these methods of qualitative data collection and to their combined use in one study are now discussed, before going on to describe the way in which participants were recruited and the data collection carried out.

Interviews

The purpose of the qualitative research interview is to "understand themes of the lived daily world from the subjects' own perspectives" (Kvale 1996 p27). Interviews are a means of finding out things which cannot be observed, such as feelings, thoughts, intentions and behaviours which took place at some previous point of time (Patton 1990). The interview is a kind of conversation: a conversation with a purpose. As Powney and Watt (1987) point out, the simplicity of the interview is deceptive. They compare interviewing with writing a book - having basic literacy skills does not necessarily lead to literary success. An interview is a point at which order is deliberately put under stress; it is a turn-taking system that requires that the interviewer proposes topics and that the respondent seeks to produce locally acceptable answers (Dingwall 1997). Dingwall (1997) suggests that even in a so-called unstructured interview what respondents say will be influenced by what they think is of interest to the interviewer.

Data produced by interviews are social constructs, created by the self-presentation of the respondent and whatever interactional cues have been given off by the interviewer about the acceptability or otherwise of the accounts being presented. Powney and Watt (1987) propose that since the outcome of an interview depends on the interaction of interviewer and interviewee, it is important to reflect on the characteristics of each. Richards and Emslie (2000) compared the impact of the professional background of researchers, one a general practitioner and the other a sociologist, in two qualitative studies, each of which involved interviews with 60 middle-aged men and women from a range of social backgrounds. Both researchers were white, female and of similar age. They found that the GP's professional status tended to obscure her personal characteristics, while the sociologist, who introduced herself as a researcher was seen as "the girl from the university." Richards and Emslie (2000) suggest that the personal characteristics of researcher and respondent are equally important and are constantly constructed during the interview. Morgan (1986) argues that personal characteristics, including gender, are latent variables, exaggerated in some cases and relatively muted in others. While it is straightforward to describe the interviewer in this study as white, Scottish, female and middle-aged, it is difficult to speculate about how these factors affected the responses participants gave without asking them directly. However, interviewees' awareness that I was a health visitor is likely to have influenced the way in which they represented their experience as parents and of the health visiting service. Based on opinions formed during encounters with health visitors prior to the interview taking place, participants would be likely to choose to portray their experience of parenthood and of the health visiting service in the light of these understandings. Since health visitors are concerned with the welfare of families and in particular children, parents may have depicted their children as being more focal to their lives than might otherwise have been the case. They may also have portrayed the health visiting service as playing a greater role than they would have with an interviewer who was not part of the service. On the other hand, parents may have felt more at ease with someone who was seen as understanding family life and who was used to dealing with the

practicalities of having discussions with parents in the presence of demanding toddlers.

Oakley (1981) suggests that interviewing is a masculine paradigm, embedded in a masculine culture and stressing masculine traits, while at the same time excluding feminine attributes such as sensitivity and emotionality. Oakley (1981) goes on to propose that there is “no intimacy without reciprocity” (p49). Fontana and Frey (1998) believe that:

“the emphasis is shifting to allow the development of a closer relation between interviewer and respondent, attempting to minimise status differences and doing away with the traditional hierarchical situation in interviewing” (p65).

In carrying out interviews and focus groups, I made an attempt to establish a rapport with the respondents, including disclosing my own status as a parent of two teenage sons. On reflection, this mirrors the approach used by health visitors to build up a relationship with parents as discussed earlier (see Chapter 3.9 pp82-85), and could be construed as a form of manipulation of interviewees aimed at enhancing the data collection, though at the time it did seem a natural aspect of social interaction with participants.

The interviews were semi-structured and in-depth and were carried out using an interview guide (see Appendix 1), which allows the interviewer “to remain free to build a conversation within a particular subject area, to word questions spontaneously and to establish a conversational style - but with the focus on a particular subject that has been pre-determined” (Patton 1990 p283).

Focus groups

Group interviewing can provide another level of data gathering or a perspective on the research problem not available through individual interviews. The focus group has generally been used mostly in market research (Hague 1993), but has recently featured prominently in health and social care research (Morgan and Krueger 1993).

In focus groups, the goal is to let people spark off one another, suggesting dimensions and nuances of the original topic that any one individual might not have

thought of (Rubin and Rubin 1995). Group interaction is an integral part of the method with people encouraged to talk to one another: asking questions, exchanging anecdotes and commenting on others' experiences and views (Kitzinger 1994). It also facilitates the use of various methods of communication employed by people in everyday interactions such as jokes, teasing and arguing. The method is frequently highlighted as a means of gaining a lay perspective on clinical or service issues (Peters 1993; Fitzpatrick and Boulton 1994; Sim and Snell 1994). They may encourage a greater degree of spontaneity in the expression of views than alternative methods of data collection (Butler 1996) and can provide a safe forum for the expression of views; for example, respondents do not feel obliged to respond to every question (Vaughn et al 1996). This was very evident in one of the groups held in the deprived area, where the playgroup leader was instrumental in encouraging two parents, one of whom had learning difficulties, and both of whom were unable to read, to take part in a discussion. These two parents made valuable contributions to the group when allowed to join in when they chose, in a supportive environment, but I felt that individual interviews would have been less successful with them and that, without the playgroup leader's influence, they would not have volunteered to participate.

As noted by Morgan (1997) the focus group "provides the rare opportunity to collect direct evidence on how the participants themselves understand their similarities and differences" (p20). This process mirrors the steps taken by researchers in trying to understand their data.

However, the group does present some specific problems which Merton et al (1956) note require three specific skills of the interviewer. Firstly, it is important that the group is not dominated by one person or small group; secondly, recalcitrant members must be encouraged to participate in order to get the fullest possible coverage of the topic. In addition, the interviewer must balance the interviewer role with the role of moderator, and simultaneously worry about the schedule of questions while being sensitive to the evolving patterns of group interaction. Because of the public nature of group interview participants may give socially desirable responses and there is a

danger of 'group speak' with participants who disagree with the consensus opinion remaining silent rather than presenting their opposing views (Sim 1998). There was evidence of this effect in one focus group, where one mother, who was on maternity leave from full-time employment, appeared to be assuming the views of the other mothers, who were either not working outside the home or were working very part-time to fit in with their partners' hours of work, for the sake of conformity.

The traditionally recommended size of the focus group is six to twelve participants (Krueger 1994). While the prevailing norm within marketing research is ten to twelve people, Krueger (1994) considers six to nine the best size for social science research. However, small focus groups with four to six participants are becoming more popular, and are especially suitable when the participants have a great deal to share about the topic or have had intense or lengthy experience of the topic. For the present study small groups provided the optimum conditions for exploring the research questions and it was obvious that parents found it very easy to talk about their experience of their role and of the health visiting service.

Typically, focus groups are guided by a few broad questions, so that participants' answers generate new ideas or connections from other group members, and the interview schedule for the focus groups in this study contained just five broad questions (see Appendix 2) in contrast to the fifteen questions which guided the interviews with parents of individual children.

4.7 Introduction to the study

The study was undertaken in a large Scottish city. Approval was given by management of the Trust and by the local ethics committee prior to starting data collection.

4.8 Selecting the Research Participants

Parent focus groups

Parents who participated in the focus groups were recruited through local playgroups. Three playgroups were chosen to represent a range of families in socio-economic

terms, and two groups were convened at each playgroup. One playgroup was in a middle-class area, one was in an area of multiple deprivation and the third was in a predominately working class area. Permission was given by the committee of each playgroup to approach parents when they were bringing their children to the playgroup or collecting them at the end of the session. As it was almost exclusively mothers who carried out this task it was inevitable that there would be mainly mothers in the groups. Only one father took part, and he was a single parent bringing up two young children by himself with no contact with the children's mother and was therefore in a fairly unusual position. Two other fathers were approached but neither was available for the following day when the group was due to take place.

At each playgroup I approached parents informally on a Monday morning, usually in small groups, and told them about the study, and that I was looking for volunteers to take part in a one of two group discussions, which would be held on the two following mornings. Parents volunteered readily, two after reassurance from the playgroup leader, and the groups took place on the Tuesday and Wednesday mornings once the children were settled in the playgroup. An information sheet (see Appendix 3) was given to those parents who had agreed to participate. Transcription of the groups demonstrated that dialogue occurred among the group members rather than between them and the moderator, which Carey (1994) suggests is important in focus groups. The parents were all known to one another to some degree, and in some cases were obviously close friends. This facilitated the inclusion of some parents who might have been reluctant to take part in a discussion with strangers, and these parents were encouraged to contribute by other members. However, there is a danger, as noted by Agar and McDonald (1995) that acquaintances rely on the taken-for-granted knowledge and assumptions which constitute what the researcher is trying to investigate. Also there may be hidden boundaries, hierarchies and rules of which the researcher may be unaware. However, the overall benefits of the interactions between participants made this form of data collection very useful when used in combination with individual interviews.

The focus group participants all had one child of around three years of age, and many had older and younger children as well. The retrospective accounts of some focus group participants who had older children were therefore mediated by time, experience and reflection. Demographic information was obtained during the group discussion rather than by more structured means. No children were attending children's centres which suggested that none of the families had child protection issues. It was not known if any of the children had special needs although no referral was made to this during the discussions.

Parent interviews

Participants for the semi-structured interviews were selected from health visitors' caseloads. The community system used by the NHS trust to collect information about health visitors' activity was used to produce a list of 720 children born over a nine-month period, from the caseloads of eighteen health visitors, chosen to provide a wide range of caseloads, in socio-economic terms. The list was then sent to the individual health visitors, and children who were not first-born, and those who had special needs, were on the Child Protection Register, or who were receiving help with parenting issues from a source other than the health visiting service, such as children's centres, were removed from the list by the health visitor. The input of the health visiting service was likely to be difficult to isolate from that of the other agencies inevitably involved with these families. For the participating families the health visitor was therefore the main source of advice and support about parenting. The children were aged about two years when the interviews were conducted. This age was chosen because parents were likely to be able to reflect on the early days which the literature review suggested were generally problematic for parents. The literature review also suggested that the toddler stage presents difficulties for parents. Parents interviewed were considered likely to have current or recent experience of childcare problems and of the health visiting service.

From the 376 eligible children, the Carstairs deprivation scores, which are assigned to all postal codes in Scotland, were used to ensure that the families selected represented a range of socio-economic circumstances (Carstairs and Morris 1992).

The families were then chosen randomly. Only one family from each health visitor took part in an interview. The parents of eighteen children participated in interviews. Demographic details of the families can be found in Appendix 4.

The permission of the health visitor and of the general practitioner of each child was obtained before writing to the parents asking for their help by taking part in an interview. Health visitors provided the names of the parents of the selected children, and these were used on the letter. An information sheet (see Appendix 5) about the study was enclosed with the letter (see Appendix 6). Parents were contacted by telephone a few days after they had received the introductory letter to establish if they were willing to participate, and if so to arrange an interview.

The letter was addressed to both parents in all but the single parent families, both of which had only a mother. When the follow-up telephone call was made, I emphasised that I could see parents at any time, including evenings and weekends, and explained that I was interested in both parents' perspectives, but left it to the parents to decide who would participate. Of the sixteen two-parent families, both parents were present during nine interviews, although in one case the father contributed very little as he was preoccupied with a very energetic toddler who was reluctant to go to bed; the other seven families were represented by only the mother. It was likely that mothers on their own often reflected on their partner's role more honestly than they would have done in their partner's presence, but on the other hand the couples often engaged in a stimulating dialogue about their respective contributions to their child's upbringing.

The parents of two children declined to take part: in one case the mother explained that her husband did not want either of them to get involved, and in another the paternal grandfather was seriously ill in hospital. The parents of another child agreed to take part, but the paternal grandfather was admitted to hospital the day before the interview was scheduled and died a few days later. Although the mother contacted me two weeks later to arrange a new appointment, I felt that it was not appropriate for her to take part, especially as I was asking parents to reflect on their own childhood, and the effect that their upbringing had on their own approach to

parenting. These two families were replaced by families from the caseloads of the relevant health visitors, having addresses with the same deprivation scores as the families they were replacing.

Two families had a second child by the time the data collection was carried out, in both cases a baby who was only a few weeks old.

4.9 Data collection

The focus group discussions and interviews were audio-taped and transcribed verbatim. The focus groups took place before the interviews. They provided rich data which were subjected to preliminary analysis prior to the interviews with the parents of individual children.

Parent focus groups

In all, 26 parents participated in six focus groups. Only one father, a single parent took part. The groups met during the play group session and mainly mothers were free during this time. Many of the participants had older children, some of whom were teenagers, so parenting in relation to various stages of development was relevant.

The discussions took place round the kitchen table in the buildings where the playgroups were being held; this created an informal atmosphere. Most of the parents knew one another, in some cases fairly well, and many had social contact on a day to day basis. The groups, which consisted of four or five members, were served coffee on arrival. I introduced myself as a health visitor who was carrying out research about health visiting and how it met the needs of parents. The discussion started by participants introducing themselves, describing their children in terms of age and sex, and saying something they liked about being a parent and something they did not like. I started off the introductions, partly as a lead to the participants and also to reveal my own position as a parent of two teenage boys. Initially this had been planned as an icebreaking exercise, but in each group the parents spent considerable time talking about the positive and negative aspects of parenthood. The participants then went on to discuss what it is like to be the parent of a young child in

contemporary society, and their experience of the health visiting service (see Appendix 2). In the first group the parents talked at length about their own childhood, both the effect it had had on their own approach to childrearing and in relation to the difference between childhood and parenthood now and when they were young. This topic was therefore incorporated into the other focus groups.

Each focus group lasted about one and a quarter hours.

Parent interviews

The interviews took place in the homes of the families at a time convenient to the parents. Because the children were at a very active stage of development, I stressed to parents that I would be happy to arrange interviews at times when the children were asleep, in order that we would be free of the distractions which are inevitable with toddlers around, not the least of which is their fascination for the buttons of tape recorders. Although this strategy involved some late-night sorties, parents were able to be more reflective when their child was not present. The semi-structured interviews covered the same topic areas as the focus groups, but the schedule (see Appendix 1) was more detailed.

The interviews lasted between forty-five minutes and one and three quarter hours. The parents of eighteen children took part, as described earlier (see section 4.7).

4.10 Data analysis

The data were transcribed verbatim. The parent focus groups and interviews were analysed concurrently. I read and reread the transcripts as a corpus to get a sense of the whole picture. I also wrote a profile of each family in order to understand the contextual factors which might affect the meaning of the interview data. Although the focus groups yielded much rich data promoted by the interaction of participants, the interviews were more orderly and detailed, and it was easier to create profiles of interview participants than of the members of the parent focus groups. The advantages of using both approaches to data collection were therefore demonstrated during the analysis.

The transcripts were then read line by line in order to identify concepts which could be translated into categories. Coffey and Atkinson (1996) suggest that researchers use data to think, in order to generate ideas that are thoroughly and precisely related to our data. Coding can then be thought of as a way of relating our data to our ideas about those data. Miles and Huberman (1994) describe coding as the “stuff of analysis” allowing the analyst to “differentiate and combine the data you have retrieved and the reflections you make about this information” (p57).

On the one hand, coding can be seen as data reduction and simplification, but coding also allows data to be expanded, transformed and reconceptualised, opening up more diverse analytical possibilities (Coffey and Atkinson 1996). Data are coded to open them up in order to interrogate them further, to try to identify and speculate about further features. Coding is used to go beyond the data, think creatively with the data, ask the data questions and generate theories and frameworks.

Tesch (1990) describes qualitative analysis in terms of decontextualisation and recontextualisation. Once the data segments have been coded, they are still not ready for interpretation. Drawing on the work of Marton (1986), who argues that each quotation has two contexts - the one from which it was taken and the “pool of meaning” (p43) to which it belongs - Tesch suggests that an organising system for data is based on developing pools of meaning.

A coding frame was devised, and gradually refined. The transcripts were then coded using the software programme NUD*IST (Richards 1997), which is a hierarchical index system used to create categories. The programme uses a tree structure for related categories, data being stored at nodes, parent and child nodes being used to relate different levels of coding, and free nodes to accommodate data which do not relate to other nodes in a hierarchical way. NUD*IST facilitates the reorganisation of data and the exploration of relationships between categories.

Hierarchical categories can be data-driven (inductive) or theory-driven (deductive). In the present study, the approach taken was inductive in that the categories came from the data, but as in any study involving semi-structured interviews, it was no

coincidence that the categories reflected the focus of the study and the open-ended questions used to achieve the aims of the research.

The data were then coded, initially manually in the margin of the transcript, and then in NUD*IST, allowing for each unit of text to be considered twice before being entered into the database. There was considerable overlap between categories, and so text units were sometimes coded several times under different categories. The coding frame is shown in Appendix 7.

The move from coding to interpretation is a crucial one as Wolcott (1994) suggests. Interpretation involves the transcendence of 'factual' data and cautious analysis of what is to be made of them. Dey (1993) argues that categorising data enables one to think about the data in a new way, but only by moving beyond the categories back to what the 'whole' picture is or may be. Delamont (1992) proposes that the process of interpretation involves looking for patterns, themes and regularities as well as contrasts, paradoxes and irregularities.

Once the transcripts had been coded, the data coded at each category were printed out and read as a 'pool of meaning,' to gain an understanding of the concept. Each transcript was then reread to look at the contextual factors which surrounded the data coded for that interview at the category node, with the aim of producing rich description. From this point analysis by writing and rewriting, as proposed by Van Manen (1990) was used to expand and reconstruct the data. By reflecting on the coded data and the contextual factors associated with the data, the analysis became more interpretive. The relevant data and reflective writing were kept together at each stage of writing. Comparisons were made between data recorded for each transcript and between contextual factors associated with participants to elicit similarities and differences. Once this process had been completed for all the transcripts, each category was written up to describe and interpret the category as a whole, with descriptions, comparisons and contrasts being used to support the interpretation of the data. Then text and contextual factors were used to compare and contrast different categories at different levels.

The analytical process is best illustrated by an example. All the data for the parent interviews and parent focus groups coded at Category 2-1-2 (Learning to be a Parent -by experience -of friends) was examined, and then I wrote about the data and the contextual factors which helped to interpret the data. I then used other categories to help in the interpretation of the data, by comparing the parent's use of family (Category 2-1-3) and their own experience (2-1-1) to the role of friends in learning to be a parent, and in comparing friends' role in learning to be a parent with their role in giving support (Category 3-2). How did friends compare with professionals (Category 2-3) as a source of advice? NUD*IST facilitated this process by its ability to identify where categories overlapped, for example, looking for a link between books (Category 2-4) and reassurance (Category 2-5), between parents 'feeling ready for parenthood' (Category 3-4) and 'expectations of parenting' (Category 4-4). In the analysis of the data, it was the use of the contextual factors at every stage of comparison and interpretation which ensured that the analysis was at all times phenomenological, keeping the participants in their *dasein*.

The findings are presented thematically in the following two chapters, after which the conceptual framework which was used to interpret the findings is outlined in Chapter 7 before being used in the final chapter to discuss the findings.

4.11 Issues of rigour

Researchers collecting and analysing qualitative data have to take serious note of the potential for bias in these processes. The problem, which is a central strength at the same time, is the reliance on the "human instrument" (Robson 1993). As Miles and Huberman (1994) point out:

" Each (qualitative researcher) is a one-person research machine: defining the problem, doing the sampling, designing the instruments, collecting the information, reducing the information, analysing it, interpreting it, writing it up." (p230)

Lincoln and Guba (1985) make a strong case for replacing the concepts of internal validity, external validity (or generalisability), reliability, and objectivity by

credibility, transferability, dependability and confirmability, which more accurately reflect the assumptions of the qualitative paradigm.

Credibility is the extent to which the enquiry is carried out in a way which ensures that the subject of the enquiry is accurately identified and described. In this study credibility has been enhanced by undertaking a step by step analysis as described, and by the involvement of my supervisors in discussing the data, the analysis process and the findings produced by the analysis.

Transferability, the task of demonstrating the applicability of one set of findings to another setting, rests more with the investigator who would make that transfer than with the original investigator, according to Lincoln and Guba (1985). The onus on the researcher is to provide the information needed to do this. Marshall and Rossman (1989) stress the need for a full specification of the theoretical framework on which the study is based. This then helps those designing studies or making policy within that framework to determine whether or not the situation described can be transferred to other settings. In this study, the integration of the three theories described in Chapter 7 enables the findings of the study to be transferred to other situations involving stress and coping, social learning and self-efficacy and family functioning.

Dependability is parallel to the conventional criterion of reliability in that it is concerned with the stability of the data over time. But in qualitative studies methodological changes and shifts in construction are expected, and are the hallmarks of a maturing and successful enquiry (Guba and Lincoln 1989). However, these changes and shifts need to be both tracked and trackable (publicly inspectable), so that outside reviewers can explore the process, judge the decisions that were made, and understand what salient features in the context led the evaluator to the decisions and interpretations made. In the present study, the intention has been to lay out the research process from design to conclusions so that others have sufficient information to make their own judgements about the dependability of the process.

Confirmability is concerned with assuring that data, interpretations and findings are rooted in contexts and persons apart from the evaluator and are not simply figments of the researcher's imagination. This means that data can be tracked to their sources,

and that the logic used to assemble the interpretations into structurally coherent and corroborating wholes is both explicit and implicit in the research narrative. In the present study, extensive use has been made of quotes from transcripts in presenting the findings of the study. I purposefully looked for contrasting cases, and distinguished between personal and conceptual thinking. Early common-sense interpretations and hunches were discarded if not confirmed by rigorous analysis; looking for dissonance and disconfirming evidence is an essential task in pursuit of rigour (Ely 1991). The use of the conceptual framework has added to the transparency of the interpretation of the findings.

Guba and Lincoln (1989) suggest that an enquiry audit be carried out, consisting of a dependability audit to demonstrate the quality and appropriateness of the research process, and a confirmability audit to show that the data can be all be traced to original sources and that the processes used to reach the conclusions are credible.

While acknowledging the inevitable effects of my background and prejudices on the research process, I have endeavoured to establish the trustworthiness of the study by making these processes transparent. Gadamer (1976) emphasises the inevitable influence of the researcher's historical, cultural, personal and professional background on the research process. As a researcher guided by Gadamerian philosophical hermeneutics, I accept that the research is an interaction between "an historically produced text and an historically produced reader" (Allen, 1995, p176). Possible professional prejudices included a desire to interpret negative comments about health visitors as misunderstandings about their role and to demonstrate that the service plays an important role in parents' lives. Personal prejudices are more difficult to pinpoint, as they are inevitably deeper and depend on the interaction of many influences. However, as a mother of two older teenage sons, my own recollections of the early years of parenthood may be affected by having, unlike the study participants, the 'finished products' and the associated feelings of satisfaction that may have diminished my memories of the stresses of the early stages of the process. The influence of my prejudices were lessened by the involvement in the analysis and interpretation of two supervisors, neither of whom was a practising

health visitor or a mother, but who inevitably brought their own prejudices to the processes, one having a background in mental health nursing and the other having extensive experience of working with children with chronic illness and their families. In some cases their interpretation of the data differed from my own, leading to discussion and reflection and sometimes reinterpretation.

4.12 Ethical considerations

Prior to commencement of the study, ethical approval was sought and received from the local ethics committee. Permission was also given by the Director of Nursing Services and the research committee of the NHS Trust in which the study took place.

Parents were informed that the interviews and group discussions would be transcribed by one secretary and that apart from this, information shared during the interview would be treated confidentially by myself. Tapes were destroyed once the transcription was completed, and the data were stored in a locked filing cabinet and on a password- controlled computer and back-up server. In reporting findings the names of parents and children were changed and no personal details which might identify participants or others, such as health visitors, were divulged.

After receiving permission from a family's general practitioner and health visitor, a letter and information sheet (Appendix 5 and 6) were sent to the parents who had been selected to be invited to take part in interviews. The parents were contacted by telephone a few days afterwards. It was made clear to participants at each of these stages and before the interview commenced that parents were free to decline to participate or to terminate the interview at any stage.

Participants for the focus groups were recruited from playgroups, after receiving permission from the committees concerned. Parents who agreed to participate were given written information (Appendix 3) and then had at least twenty-four hours for consideration before the focus group was convened. Participants were informed that they were free to leave the group at any time.

There was the potential for problems to be revealed which required professional intervention, particularly the disclosure of possible child abuse. While this did not

arise, I would have felt obliged to pass on any concerns to the family's own health visitor or address any urgent issues as I would when working as a health visitor.

Some of the topics which the interviews addressed, especially in relation to parents' own childhoods and to their isolation from family, made parents reflect on aspects of their lives in a way they previously had never done. I was careful not to probe areas which were sensitive to participants and to balance the quest for rich data with respect for parents who had kindly volunteered to participate. As an experienced health visitor, I hoped that I was able to anticipate and manage potentially distressing situations with reasonable expertise, and my overriding principle was that of beneficence, which encompasses the maxim: Above all, do no harm. During the data collection, it became clear to me that situations must be dealt with as they arise, and that ethics is a matter of putting the welfare of participants before the aims of the research.

In the focus groups, the main ethical issue was to try to minimise the possibility of participants disclosing information or opinions which they might later regret, especially when participants knew one another. This was managed by my taking care not to ask any questions to individual participants which might lead to the disclosure of information and views which the participant might later regret.

4.13 Summary

The study methods were selected to facilitate the collection of the most appropriate data about parents' experience of their role and of the health visiting service within the context of contemporary parenthood. Hermeneutic phenomenology provides a useful philosophical approach to the study of the 'lived experience' of parents. The particular strengths of focus groups and interviews combine to give a breadth and depth which would not be possible using only one of these techniques. Analysis was carried out thematically and then interpreted using a conceptual framework consisting of theories which appeared to elucidate the analysis and render the findings more generalisable.

CHAPTER 5: THE EXPERIENCE OF BEING A PARENT OF A YOUNG CHILD

5.1 Introduction

The literature review revealed a paucity of recent research about family life with young children, apart from Brannen and Moss's (1991) study of families where both parents were working full-time, for which the data collection was carried out in the mid 1980's. While classic studies, such as those carried out by Bott (1957) and Newsom and Newsom (1963) provide an interesting historical backdrop to this study, changes in family structure and function have resulted in the findings from those studies being of little relevance to today's society.

This chapter presents the findings from the interviews and focus groups held with parents about their experience of being a parent, how they learned the skills necessary to carry out their role and the support systems which contributed to parents' success and enjoyment of bringing up young children. Parents' reflections on different aspects of their experience of parenthood, as well as on the ways in which they changed their perceptions as their children grew and developed, are explored. Issues relating to mothers and paid employment and the involvement of family and friends in family life are examined.

The literature review revealed that much of the research on motherhood was relevant to parenthood generally, while almost all studies about fatherhood focused on the father's role in relation to that of the mother. This situation was replicated in the findings. It was therefore decided to present the findings as the experience of parents, with an acceptance that most of the participants in the study were mothers (as discussed in Chapter 4.7), and to then devote a section to fathers, as the analysis of the data revealed the same trend as in the literature with respondents tending to discuss fatherhood in comparison with motherhood.

The names of respondents have been changed to provide anonymity. The source of quotations is given as line numbers from the transcripts of interviews (abbreviated to 'Int.') and focus groups (abbreviated to 'FG')

5.2 Commitment and responsibility

The commitment and responsibility felt by parents towards their children was very apparent during the focus groups and interviews. Even parents who had good family support said that they felt that the ultimate responsibility for their children lay with themselves. Elspeth expressed this sentiment:

“Being a parent is about being responsible, you’re responsible for your child and no-one else can do that for you.” (FG2: 515-517)

Parents felt burdened not only by day-to-day obligations but also by the long-term responsibilities associated with their role. Catriona (Int.12) described how this responsibility became apparent to her when she came home from hospital, even though at this early stage she might have been expected to be pre-occupied with more mundane and immediate concerns:

“I think when we first got home it was suddenly ‘oh my God’ we’ve got this person that is solely our responsibility, you know and I think it’s just knowing what you do to, you know, from then, that point on, you were forming his character for the rest of his life, I think.” (Int.12: 201-205)

Bringing up children was portrayed as an onerous task, with parents believing that they were accountable for their children’s welfare both in the short and long-term.

5.3 The transition to parenthood

The literature review suggests that the transition to parenthood is generally problematic to most parents, and that the early days are particularly difficult. The parents’ accounts of the early days support this idea, as not only were there physical problems such as fatigue but also an overwhelming sense of loss of independence and of freedom.

Dawn (Int.8) highlighted her feelings about losing her independence:

“I found it a shock and got upset that I wasn’t like me any more, I was just his mum, but then I just got used to it and just figured out that I’d got to get on with it and just do it.” (Int.8: 93-95)

This sentiment supports Rogan's (1997) theory that women's transition to motherhood involves a change from feeling that "this isn't my life any more" to accepting that "this is my baby and I have to care for it" (p881). Barclay's (1996) concepts of loss, realising and working it out are well illustrated by Dawn's reflections.

Diana (Int.18) described how it was difficult to become accustomed to always having the baby with her:

"It's getting better now, but that first year was - the first year and a half was really hard from that point of view. Em it was hard to get used to being totally demanded all the time and not being able to just go downstairs and walk to the shops and do something on your own. You know everything had to be sort of worked around this little person that had entered your family you know. I mean it's not that you don't like it, but it's just a hard thing to adjust to." (Int.18: 23-229)

Parents said that they considered the child's needs always had priority over their own, and that they had lost their own sense of identity, and also alluded to the long-term nature of the commitment. Linda (Int.6) commented that:

"It's such a long time that you are a mother, you may be someone else as well, but..." (Int.6: 678-680)

Many parents talked about the transition to parenthood as having a surprise element to it, even though they recognised that they had had many months of preparation. Dave (Int.17) summed up the difference between his expectations and the reality:

"People used to come out wi' the wee problems, this that and the other and you used to think. Mmmh, mmh, heard it, and then once you see it for yourself and you're in the battle field as such you realise just what there is involved." (Int.17: 82-85)

These findings suggest that the initial stages of parenthood are more accurately portrayed as a "crisis" (McMasters 1957) than as "slightly difficult" (Hobbs and Coles 1976).

5.4 Experience at different stages

Many parents said that childrearing improved as their child grew. Initially two factors conspired to make the transition difficult: getting used to the parental role, and coping with the practicalities of the early stages which many parents described as being very difficult.

For parents who had 'text-book babies,' who slept a lot and were generally considered good, the early days were described as "a doddle," (FG3: 461) although one mother found the baby stage boring because her baby did nothing but eat and sleep. Deirdre (Int.18) felt that the first year was quite tedious because there were limited things she and her child could do together. As her child grew and became more responsive, life became more sociable and fun. This was particularly important to Deirdre because, as a teacher, she particularly enjoyed being creative and teaching her child new skills and encouraging her language development.

For many parents, however, the early days were marred by babies with colic and breastfeeding problems. This was exacerbated by parents believing in the early days that all problems in the child were the result of incompetence on the part of the parents and that they were to blame for the child's distress. Parents talked about wondering what they were doing wrong when their babies were unsettled. Breast-feeding, especially when it was not well established and the baby was feeding frequently, made some mothers feel their loss of independence more acutely, because they could leave the baby for only very short periods, could not plan activities in advance, and felt that they were controlled by the baby.

Some parents resented the pressure they felt had been put on them to persevere with breast-feeding even when they believed that there was no chance of success, and would either opt for formula feeding from the beginning or would decide to give up much earlier if it was not successful. One mother, who had recently had another child, was formula feeding confidently from the start, because she considered that the first child had not experienced any adverse effects from formula feeding which was only introduced after a prolonged and unsuccessful struggle to breastfeed. Colic and breast-feeding problems often combined to reduce parents to a state where they were

“washed out with lack of sleep and irregular hours and were walking around like zombies” (Int.12: 693-695). For some parents the resolution of colic and feeding problems had happened over a very short period of time and made a dramatic difference to their perception of their role. Joyce (Int.7) described how:

“Being a mother was a totally different experience and I felt as if I was really enjoying him for the first time.” (Int.7)

Once babies were fully established on solids and having three meals a day parents’ lives appeared to be much easier.

Part of the reason that parents blamed themselves was associated with the feeling that they did not yet know and understand their child, and this was made easier when the child was a little older and “more of their own person” (Int.17: 397-398) and could also communicate with the parents.

The increasing ability of children to communicate made it easier to work out the cause of children’s distress and also made being a parent more interesting and fun, and allowed the relationship between parents and children to flourish. The acquisition of language transformed children into “real little people”(Int.18: 66) and also allowed parents to engage in more interesting and creative activities with their children. However, one mother, whose baby was more alert from the beginning than she had expected, found that she enjoyed the baby stage more than she had envisaged, because her baby had been “a real wee person right from the start” (Int.15: 46-47), and she had got to know her very quickly. Thus getting to know and understand children was considered an important development which enhanced the rewards of parenthood, and helped to create parents’ perceptions of children as individuals. This development is similar to Barclay’s (1996) concept of “tuning in.”

Rosemary (FG4) described how, when her child was very young, she worried about the child’s performance but was now aware of how little influence she had over him:

“Certainly as he’s got older I’ve worried less and less and less about whether what he’s doing is normal, at the beginning for the first year or so I was so obsessed. He’s doing this now, he’s a monster and someone would say “They all do that” and so I don’t worry about what he’s doing, but more and more I worry

about what the correct response is so I can maximise my opportunity of getting rid of this behaviour like his whinging. Do I punish it, do I ignore it, and I'm laughing about it, because I'm not actually worried about him whingeing because they all whinge so I have shifted my concern from him to me." (FG4: 373-383)

Now she was more concerned at examining her own performance and how she handled her child.

As children matured they could amuse themselves more, playing with toys, whereas most babies required attention from their parents all the time they were awake.

The two families who took part in interviews who had second babies were finding that they were far more relaxed second time round. The parents in the focus groups who had more than one child reported feeling more confident with subsequent children, although it was acknowledged that coping with two children and their different needs presented new problems. They felt that with the first they were always anticipating the next stage, checking that the child had reached the appropriate developmental milestones and pushing him/ her on to the next one whereas with subsequent children they let the children go at their own pace and enjoyed their current stage of development.

5.5 Parents' experience of their role

Parents reflected on the experience of being a parent mainly in terms of how they had anticipated their role: some aspects were better than expected, some worse and some just different. Parents' expectations were influenced by any previous contact with children. Initially, however, most parents found it difficult to articulate their sentiments about parenthood. Eleanor (FG2) gave a typical response:

"What do I like about being a parent? Em, I've never really thought about it. They're there so I just get on on a day to day basis." (FG2: 14-16)

For many parents, even in an era when having children is a matter of choice both in terms of contraception and of alternative means of self-fulfilment available to women, having children appeared to be a taken-for-granted aspect of their lives.

Experience and expectations

Some parents had had considerable 'hands on' experience of children. Two women had older sisters who had stayed with their parents and themselves in their early days of parenthood. The childcare had been shared within the family, the study participant mothers having taken on considerable responsibility for their nieces and nephews. Mothers with much younger siblings also could remember what they were like, though in one case the mother really had had little involvement with her brother who was twelve years younger than herself. Fathers were considered by both mothers and fathers as having less experience of children.

Some parents had had very little contact with babies and young children though some of these parents had tried to imagine what it would be like to have a child of their own when they had started thinking about having children.

Parents who had been closely involved with children prior to having their own, especially those who had been brought up surrounded by children in an extended family, expressed few surprises about the reality of parenthood. It appeared to be very much a part of life to them. For example, one mother associated her sister having children with her always being hard up; this had been her own experience, so came as no surprise. However those with little previous contact with children were clear that no-one could really have told them what it was like and that there was no way they could have envisaged the changes ahead. Likewise, parents felt that they could not explain to prospective parents what having a child was like.

Some parents had formed a mental picture of what family life would be like before having a child of their own.

Lorna (FG3) had an image of how she imagined family life:

"But I thought that you know with my own skills, I would be able to have a nice, happy family (laughter). We'd be able to go out, be able to enjoy ourselves, I mean OK, we'd have the tantrums, but we'd go out, have a nice time. Come home again." (FG3: 61- 64)

Eileen (FG4) had expected her children to go to bed at a reasonable time and to have evenings to spend on her own or with her husband, a situation which had not materialised. She also had her idea of family life:

“ I think I had an image of like there would be times when we all did things together and then were times when the children were in bed and you were left with your husband. And this has just not happened at all. Em. When we do - we never all - I think possibly because they're split - the age gap is so wide we never all do things together any longer. There was a time when there was just the two when we did. The only time we ever do anything all together is when we're on holiday and I find holidays so stressful I'm honestly dreading the one that's about to come, because last year after 3 days I said I'm never ever coming on holiday with you lot ever again. I don't know whether it was the children or my husband or the combination of them all. I don't know what, but I was a nervous wreck. But it hasn't actually quite turned out to be quite as I expected” (FG4: 61-74)

It was particularly the image of the 'happy family' that parents found did not really materialise in the way they had anticipated.

Positive aspects

For some parents, the positive aspects seemed to be simply the pleasure of being with their child, “just having him,” (Int.8: 5) and having fun.

Some parents said that they had not anticipated some positive aspects of parenthood. Their strength of feeling towards their children and about their children's achievements surprised some parents. This was demonstrated by the reflections of one group discussion (FG1):

Isobel - “ but the rewards are there as well. The rewards are much greater than I had anticipated. I mean I just had no idea how I'd feel when they said their first words, took their first steps, and seeing them showing an interest in reading and writing. And they're just so much fun sometimes. Each little developmental step. You don't expect to have such feelings.”

Shirley - “Yes, it's when you, like when you come to pick them up from playgroup and they see you and then they just run totally into your arms.”

Isobel - "Yes, you can't really describe that feeling."

Shirley - "Before you have your first child, you kind of think, well you assume you're going to love it. But you've no idea you're going to be so..."

Isobel - "...so bowled over by it. It just completely takes over." (FG1: 38- 51)

Although Isobel described her children as fun, the emphasis was on the rewarding experiences and the unique bond which parents seem to believe exists between parents and their child.

Negative aspects

Most parents found parenthood harder work than they had expected, and the lack of sleep and permanent tiredness, although anticipated, were much worse than they had envisaged. The feeling of permanent responsibility for their child, never being off-duty, was also greater than expected. Carol (Int.11) said that even if she and her husband were out on their own for the evening, the child was always at the back of her mind. In addition, she was afraid to have more than a very small amount of alcohol as she would have to resume responsibility for the child as soon as she returned home, and did not like being late back because her child was an early riser. These factors meant that for her a 'night out' had limited appeal now compared to previous times.

Parents did not expect to take so long to organise going out, every outing seeming like a military operation, and did not expect that it would be so difficult to do things spontaneously, needing to arrange babysitters in advance.

As well as expressing feelings of loss of independence and self-identity, the parents who participated in the study were more concrete in their descriptions of the negative aspects of their role than of the positive features, and mothers especially often referred to every-day situations. The day-to-day tedium of domestic drudgery associated with children predominated parents' accounts of the downside of childrearing. Elspeth (FG2) described how she felt that clearing up after children prevented her from spending time with them:

“ Sometimes you’re so busy, you don’t have time to enjoy them the way you should. I know I felt that way yesterday. I actually had no time to spend with my children because I was spending so much time just tidying up after them, and catching up. You can’t be prepared for that.” (FG2: 150-154)

Parents generally described spending time with children in very positive terms, but the total experience of childcare was associated more with clearing up after children than with interacting with them.

Just different from expected

Rosemary (FG4) was surprised at how little influence she had over her son, and had thought that she could mould him into the child she wanted during the first year. She found that he came with his own personality:

“ I think I didn’t know anything about them growing, so I am a bit shocked that he’s not a baby still, em, I am a bit shocked about how much or how little influence I have over what he is or what he chooses to be. I think if I get things right for the first year and a half when he’ll turn into that and that will be great and of course it doesn’t work like that.

I enjoy it more than I thought. I work full-time as well, and I find it very very tiring, but I get a lot of more out of it than I expected to. I don’t think I expected to get as much of a buzz out of it. He’s been a relatively easy child, the last wee while. But I think definitely I thought, I’ll have a baby, and then that would be a baby and will be around for 10 years or something as a baby, and of course that’s not true. So it was different as in the baby side of it went past very quickly and we got into the stage of having a given person with their own mind and will and all the rest of it quite quickly and I was quite shocked at that. (FG4: 76-91)

Like many other parents, Rosemary was surprised at how quickly her baby had developed into an individual and had expected the baby stage to somehow last longer. For many parents the experience of parenthood seemed to be associated with surprises.

Most parents did not expect to identify so closely with their own child, and to ‘see themselves’ in their child, in appearance and personality. However, one father with a

long history of infertility had often imagined what it would be like to have a child, and the reality matched his expectations. He had particularly anticipated being able to see his child as reflecting himself to some degree, and although he did not allude to the possibility of adoption in the past, there was an implication that having his 'own flesh and blood' had particular significance for him.

5.6 Parents' aims and aspirations

As well as being concerned about their children's present welfare, parents also looked to their children's future, in the same way that the mothers in Boulton's (1983) study talked about hopes, dreams and ambitions for their children. They talked about the aspirations they had for their children, both in terms of their children's futures and also of the strategies they intended using to optimise the chances of realising their goals. Parents' ambitions for their children were usually described in comparison to their own upbringing and perceived success and happiness, with some parents anxious to recreate what they had, and others wishing their own children to have a different experience of childhood from their own and/or to achieve more than they had. Parents said that they wanted their children to have fun and intended to provide opportunities to ensure that they did. They referred to everyday aspects of life they remembered as being important in their own childhood such as bathtime rituals and special times such as birthdays and Christmases. Elspeth (FG2) modelled herself on her own mother, because she felt that she could do no better, and because, like her mother, she had given up paid employment and did not intend to go back to work till her children were much older.

Joyce (Int.7), whose father was an alcoholic, recalled that her mother's life had revolved too much round her sister and herself. While in some ways it was good, and her mother always made their friends and boyfriends welcome, they felt "terrible" when they left home, because "she depended on us more than we depended on her" (Int.7: 236-237). This mother did not want her child to feel the same way, and even although the child was very young, she envisaged the day when he was gone and wanted to make sure that she had a life of her own.

Gerry (Int.16), who worked as a window cleaner, had already set high goals for his son:

“Hopefully he’ll be a wee lawyer or something like that and make lots of money and be able to have a good life.” (Int.16 288-292)

The family lived in the catchment area of the same school which the father had attended and believed had given him a poor education, and already he was planning to ensure what he saw as a better education for his son by sending him to a private school. This father had aspirations for his son and had planned ways he thought would increase his chances of achieving them.

Jenny (Int.9) who had grown up as one of a large, poor family, hoped that she would be able to provide her child with more than she had had, but at the same time was anxious that he would appreciate things and not take them for granted.

One mother wanted to “create an new model” (Int.18: 390) of childrearing combining some of the approaches used by her parents with some new strategies, based on a more egalitarian relationship; this seemed especially important to her because she was not expecting to have any more children, and she felt that this would be appropriate for an only child and compensate for her daughter having no siblings to relate to on an equal basis.

Parents had discussed the ways in which they aimed to achieve their aspirations and give their child what they considered to be an optimal upbringing. Sometimes this was expressed in more abstract terms, as one mother described:

“I don’t know whether it’s right or not, but we made a conscious decision that when we had a family they would be number one.” (Int.12 1058-1060)

In other cases, parents spoke in more concrete terms; the mother would give up work to devote time to children or they would “encourage them with their studies from an early age” (Int.12: 1396-1397).

Analysis of the data revealed the importance parents accorded to providing their children what they believed to be a good experience of childhood and to preparing their children for adulthood.

5.7 Parents' approach to disciplining their children

Parents' feelings of commitment and responsibility to their children have already been discussed. They displayed a sense of duty to give their children the best possible start in life and to produce an adult who would have the ability to fit into society. They also had aspirations for their children and thought about how these aspirations might be achieved.

In order to achieve these goals, parents often talked about issues relating to discipline; the term was used to describe both guidance, showing children the right way to behave and punishment, chastising them when a misdeed had been committed. Parents frequently referred to their own upbringing in relation to their views about discipline. Discipline was considered to be necessary for two reasons: because it was inherently good for the child and in order to make life tolerable for the parents. Parents said that they had to find a balance between being too lenient, which they saw as leading to children having no boundaries, and too strict, which would deter children from approaching them with problems which the parents would want to help to solve. They also wanted to balance the need for fun in childhood with the need for the imposition of rules, as Jasmine's (Int.2) comment illustrated:

I think you know he's a child and he has to have some fun, but you've got to draw the line somewhere because he has got to learn." (Int.2: 344-345)

Parents said that they believed that their responsibility as parents included teaching children the difference between right and wrong, and helping them to learn socially acceptable behaviour and respect for others. They were also anxious about their children's behaviour reflecting well on themselves as parents and were embarrassed by children behaving badly in public. Parents also expressed the view that children have to be taught how to behave and that they do not acquire the necessary skills

automatically as they develop. Deirdre (Int.18) described why she considered discipline important:

“I want Lucy to be a sociable person who can relate to other people in a civilised way.” (Int.18: 405-406)

Discipline was said to make children feel secure, as children were said to “respond to certain boundaries” (Int.18: 420), and Deirdre went on to express her views on the dangers of not imposing some limits on children:

“And it’s finding that fine line between not being so sort of liberal that your child just doesn’t feel they’re loved...” (Int.18: 559-560)

Children were said to need freedom and the opportunity to experiment and parents were aware of tensions between allowing children to learn from experience and guiding and protecting them.

Discipline started for many families in the early days, when parents began to try to establish some degree of routine with their babies, partly in the hope of making the baby more settled and also to give the parents some sense of order and control. For many parents the establishment of sleep patterns was their first attempt at imposing their will on their child. Some parents described how they had seen their baby’s failure to settle as a sign of distress, but then realised that if left to cry the baby learned that it had no effect. Linda (Int.6) described how she took control of her baby’s bedtime demands:

“Because I was quite soft at first but you had to have a stage where .. he used to every time I put him down to go to sleep at night he’d cry and I thought ‘ oh no, he must still be hungry’, feed him again and he’d fall asleep a few seconds later, but it was fear of putting him down on his own to go sleep without rocking him to sleep but I just one night said, ‘ no, I’m not going to do this any more,’ one night I stood for an hour and a half trying to get him to sleep under the light and every time I put him down in his cot he woke up so I just left him one night to cry for 20 minutes and he went to sleep and after that he just knew that when he got put in the cot he was going to his bed.” (Int.6: 550-560)

Thus Linda increased her confidence in her parenting skills by learning to manage her child's behaviour successfully.

Carol (Int.11) had had a strict Catholic upbringing but had lapsed a long time ago, and recalled how she had hated being made to go to church as a child. However, she had started to take her son to a non-Catholic church and intended to send him to Sunday school. She described her reasons for doing so:

“Cause we were made to go. But I started taking him to church and I thought like I’ve never been there for years but I’ve started taking him. Not because I want him to be a holy Joe or anything. I just think it’ll give him a good moral background...He’ll be going to Sunday School. So I think that’ll be good for him. Well as I say I don’t want him turning into a right bible basher but I just think em he’ll learn the difference between right and wrong. I think that’s basically it.” (Int.11: 785-789, 803-806)

Parents’ comments suggested that they believed that providing some sense of order and morality for their children was an important aspect of their role. This sentiment accords with their overall aspirations to prepare their children for adulthood, and to give them the skills to cope with the demands of their future lives.

Dealing with children's unacceptable behaviour

Discipline was considered necessary in order to establish good behaviour and attitudes in children. Dealing with unacceptable behaviour was an issue which caused parents some anxiety and confusion and many had ambivalent views about the place of smacking in dealing with their children's misdemeanours. Some parents said that there was little general consensus about how to deal with children when they misbehaved and that they were in a ‘no win’ situation. Jackie (FG3) illustrated the dilemma which parents are in:

“If your child throws a tantrum in a shop people look at you as if you’ve got two heads if you leave them- you’re a terrible mum. And then they look at you if you smack them so you cannae win.” (FG3: 839-841)

There was a general consensus among parents that smacking children in public could have repercussions as Lorraine (FG5) explained:

“It’s different now from when we were children, I mean, you have got to watch every step because I mean if you’re outside and you smack your children and before you know it you could be under report to the social services. When we were brought up a quick clip in the ear was OK.” (FG5: 466-470)

Wendy (FG6) explained how she believed that parents have been told not to resort to physical punishment but have had little guidance about alternative strategies:

“I think there’s been a phase, maybe last ten years, ten or eleven years, and parents have been told you’ve got to let children express themselves and you’re not allowed to smack, not allowed to tick off. I think there was confusion about discipline and I think our age group, you know with kids, we have actually suffered from that because I think there was a confusion about that. But you know, I think that comes from professionals and academics, you know they’re the ones that tell us how to be parents, I don’t know, I think they’ve got it wrong.” (FG6: 133-141)

Many parents appeared to believe that physical punishment was the only way of managing children’s negative behaviour and that they were faced with the choice of smacking children or not reacting at all to their misdemeanours.

Some parents said that they did not find smacking effective, because it did not stop children repeating antisocial behaviour. Liz (FG3), who had three children under the age of five, found that if she smacked the older one, he smacked the middle one who smacked the youngest one, and she therefore could see the negative effects of physical punishment immediately. Catriona (Int.12) explained that she tended to be half-hearted in her approach to smacking and that this was probably the most ineffective approach of all:

“Well I’m trying to get away from smacking because I don’t think it’s doing any good. It just makes him laugh and lash out either before or after you do. I don’t know. This is an area where I don’t really know what’s best.” (Int.12: 262-265)

Some parents, although acknowledging that physical punishment was a contemporary social issue, said that they believed that it did have a place in bringing up children. Others described situations where they were very angry with young

children, and snapped, but it brought a confrontational situation to a head. Alastair (Int.12) described the scenario:

“But at the time he just gets a smack because he’s being naughty. You don’t debate it on the spot you know it’s just a smack because he’s being bad or whatever. You might think about it later but...” (Int.12: 286-290)

Alastair’s comment suggests that in retrospect he regretted the use of physical punishment. Many parents related examples of situations where they had smacked young children and had felt so guilty about their perceived misuse of power, that they had always immediately compensated for it by showing affection to and apologising to them.

Lorna (FG3), who had worked as a nurse with emotionally disturbed children, knew all the alternative strategies and tried to use these, but she described getting to the point where she felt that she would lose control completely if she resorted to smacking:

“But I think that with Nicola I did the excluding and I did the time out, I did the withdrawal, I did all the rest, and I got to the point, when I thought ‘I should just have smacked you and it would be finished, and I can’t lay a hand on you now, because I could kill her’ (laughter)..it was just going on and on and on. You know, like within a half-an-hour or hour period. It’s like ‘I should have smacked you’ because by now it had got that I was so angry that if I started smacking I wouldn’t stop because it would have been sheer temper, frustration and everything else.” (FG3 230-234, 241-245)

Lorna therefore acknowledged the stresses she felt were associated with using strategies to discipline children which do not involve physical punishment.

Influence of parents’ own experience of discipline and physical punishment

Many parents described their own upbringings as strict, both in terms of physical punishment and in terms of the relationship they had with their own parents. Much of it was generally accepted as part of childhood, the “clip on the lug” (FG5: 235) or “a slipper on the backside,” (Int.10: 164) being considered an accepted part of parents’ childhood, as well as an expectation that parents’ authority would not be questioned.

There were mixed views about the usefulness of the strict regime to which many had been submitted, some thinking that “it didn’t do us any harm” (Int.11: 744) and others recalling that they were scared of their parents and would not have approached them if they were in trouble because their parents would have punished them rather than offering any help or advice. Some parents, even of those who felt that it had done them no harm, were trying to be less strict with their own children, but said that they found this approach took more effort. Maggie (FG3) reflected that:

“We didn’t have this bargaining and communicating. You were just told to do it and you did it. They didn’t have all the psychology books about time out and you think oh gosh if I’m not doing these things then I’m not a good wholesome parent and then you sort of try them out...” (FG3: 311-315)

The use of reasoning and negotiation were therefore considered to take more of parents’ energy than a more didactic approach to discipline. Maggie’s comment demonstrates the conflicts created by changing social expectations as discussed in the review of the literature (Chapter 2.2).

Rosemary (FG4) reflected on her parents’ discipline strategies and her rationale for not adopting the same approach:

“Well, my parents were a lot more controlling. I tend to go for the psychological route. I’ve got all the books, what Dr Green has to say about it, toddler taming all that. My parents just went for the discipline - we say, you do, kind of line - and I can see the pros and cons of each side, and I can see that they think that I’m a bit woolly and airy fairy. But then I think it’s much better to develop along those trendy lines, but there again I think Craig could do with a wee bit discipline from time to time...the bit that sticks in my mind was that everything was non-negotiable... The most important things for me as far as is humanly possible is that they will come to me for whatever and I do know that I didn’t do that with my parents, because I wouldn’t dare. Whatever it is, I need him, I need to try to get him to come to me first and he’s not going to do that if he sees me as a disciplinarian.” (FG4: 141-148, 273-275, 284-288)

Mandy, who could recall the fear she had for her parents outlined how she hoped that her own child would not have the same feelings towards her:

Mandy- "You've just got to let them know that you're there for them and you'll help them if you can and you'll keep them right if you can but to keep the communications open so that they're not frightened to come and say 'look, well, I've broken a window or I've got a row from the teacher at school.' I wouldn't dare have gone home and said I'd had a row at school."

RH- "Do you feel you want the opposite from what you experienced as a child?"

Mandy- "Obviously she'll know that you're going to discipline her at some point but rather than her sort of saying 'I've done nothing' type things and lying, and trying to hide things if it's more open she can say 'Well, look I did whatever it was and know that you're not going to go just totally ballistic about it.' I would like to think that she would feel that she can come and ask me to help her to sort out problems rather than just go off at the deep end." (FG6: 522-539)

Many parents therefore seemed to believe that the "psychological route" was worth the effort, as it would encourage children to see their parents as approachable and understanding. Children would be more likely to come to them for help in resolving problems, giving parents the chance to teach them how to tackle problems in a way which would be of benefit in the future.

There were some difficulties with using reasoning with children. Eileen (FG4) spoke of being aware that there is a conflict between negotiation and consistency, but that if she was not prepared to change decisions after hearing her children's point of view, then there was no point in pretending that she was prepared to listen to them. She described her dilemma:

"If you think about it theoretically it's important to be consistent but it's difficult to be consistent and also come into negotiation because you find that you look back and think - that wasn't very consistent. But then unless they feel that through negotiation you might actually change your position, it's not negotiation at all." (FG4: 520-525)

Some parents, who were aiming to be less authoritarian than their own parents had been, attributed their parents' attitude to factors such as a larger family size. One father, Dave (Int.17), who claimed that he would never be very strict with his own

child, a daughter, recalled with affection his mother's strict regime. He was one of four boys, and realised that his mother had to keep a tight rein on them in order to exert some control. However there had been a camaraderie among the boys which persisted to the present time and a fondness for their mother who, according to the father, would have done anything for her sons. This perception compares with Deirdre (Int.18) who was hoping to have a relatively egalitarian relationship with her daughter who was likely to be an only child, suggesting that parents ascribe themselves various roles depending on the family composition.

Some parents saw advantages in their own strict upbringing. Barbara (Int.3) described how she considered her mother to have been consistent and fair in her use of physical punishment and therefore felt that it has a place in disciplining children:

"I don't think there's anything wrong with smacking within reason, I don't think you should beat the living daylights out of him. My mum, we knew how far to go before you got smacked and you had to do something pretty good to get smacked, so you knew how far you could push it and we were like 'quick, back-off, run. I've annoyed her now.' But I think smacking has got a place." (Int.3: 743-747)

Likewise, Lorna (FG3) accepted the type of discipline which prevailed when she was young:

"I know when I was a child, if I was misbehaving in a shop or I was cheeky to somebody you got it and you expected it and OK it probably wasn't right, but you learned to respect people." (FG3: 905-907)

Physical punishment seemed to provide simple rules which children understood and taught children how to behave. However, parents seemed to believe that using this approach with their own children would compromise their relationship with them.

Graziano et al. (1996) found that children accepted physical punishment as a parental right; the findings from this study suggest that this belief often persists into adulthood.

In contrast, Maggie (FG3) recalled a single episode when her father had smacked her when he was wanting to get on with winemaking and she had been annoying him

when she was merely curious about the process involved. She remarked that she still felt indignant about it, but realised that, as in the incident with her father, her own reactions to her own child usually depended on other stresses and demands rather than the child's behaviour.

One father, Jim (Int.10), who has served several prison sentences and was brought up in a notoriously tough area of Glasgow, recounted how his father had given him "hidings" for getting into trouble with the police, and had on occasion, broken his jaw and his nose.

"It's different to the way I was brought up because when I was brought up I was punished for things. I've had eh a broken nose off ma faither. I've had a broken jaw off ma faither. I've had broken ribs off ma faither and so forth. So I wouldn't say I was bringing Gordon up the same as the way I was brought up. Ma faither was born and brought up in the Gorbals in Glasgow and he was used to the rough activity and so forth and he ta'en it out on us. We were all the same." (Int.10: 134-41)

He was also encouraged by his father to retaliate to provocation and would instil the same ideas in his own son. Jim demonstrates the intergenerational transmission of harsh parenting found by Simons et al (1991) although he suggests that he would not resort to the brutal punishment to which his own father had resorted.

Another woman (Int.14) recalled being made to eat food at one meal that she had refused at a previous meal, and could still recall the misery it caused her, and so she would never do the same to her own child.

Although many parents were critical of the discipline which was accepted in previous generations, they often also attributed the rising rate of juvenile crime and a perceived increase in the number of badly behaved children to the shift to a more egalitarian relationship between parents and children.

When parents were reflecting about their past, they recalled that although parents were stricter, children had far more freedom compared with today's children. This freedom to some degree balanced their parents' discipline, as parents could remember how, as children, they were able to go off with friends for many hours at a time, especially during the summer months. Parents who participated in the study did

not envisage giving their own children this liberty, and even parents of very young children had already considered the need for supervising their children in the future and the use of modern technology such as mobile telephones to monitor their whereabouts. Parents associated discipline with curtailing children's freedom in order to ensure their safety as well as with controlling other aspects of children's behaviour.

Looking for guidance and alternatives to smacking

Some parents expressed a need for guidance in how to discipline their children and were unsure about alternative strategies. Wendy (FG6) was having problems with her daughter and asked the leaders at her daughter's playgroup for advice. They talked about 'time out' (removing the child to another room for a short spell) and other strategies, and explained the rationale behind them. In addition they explained about the developmental stage the child had reached and her need to test boundaries, which Wendy found gave her an insight into the problems she was encountering. They also gave her a book on toddler-taming which she found helpful; it said that nothing would be gained by both parent and child screaming at one another and so when the child had had a tantrum the mother had sat beside the door and waited until her child calmed down and came to her for comfort. The mother said that she now saw her daughter's behaviour as normal rather than deviant, and did not interpret her tantrums as personally hurtful. Moreover, she would feel more confident about handling difficult phases in the future. Many parents who took part in the focus groups and interviews did not know about alternative strategies such as 'time out,' and did not have an understanding of child development in relation to this area. The data suggest that parents would benefit from help at the toddler stage in learning to manage behaviour, and the one mother who had sought and obtained help appeared to gain many benefits from it.

5.8 Fatherhood

As described earlier (see Chapter 4.7 p108), all of the nine fathers who took part in interviews were interviewed along with their partners. The other father, a focus group

participant was a single parent. The findings therefore comprise reflections on fatherhood: by fathers, in all but one case in the presence of the mother and by mothers, alone or in the presence of fathers. As in the literature review, the analysis of the data relating to fathers revealed an emphasis on the ways in which fatherhood differed from motherhood.

Both mothers and fathers said that fathers were generally less involved than mothers in caring for children, because in most families the mother was not working or was working part-time. Four couples who were both working full-time shared the care and responsibility of the child to a much greater extent than the other families in the study. This replicates the findings of Martine and Roberts (1984) and Ferri and Smith (1996) that fathers become more involved in child care as mothers are employed outside the home more.

Both mothers and fathers acknowledged that mothers played the key role in the early days; in the case of breast-fed babies this was attributed to the fact that the father had a subsidiary part to play as Linda (Int.6) explained:

“I think he felt at first I was feeding myself a lot as well, so it was me getting up in the middle of the night, there was no point in him getting up to lift a baby to give to me so it was me getting up which was really difficult at first, but the older he gets the more help Alastair can give as well. Obviously I’ve got him most of the time because I only work part-time.” (Int.6: 494-499)

However, mothers who had bottle-fed from the beginning also appeared to be seen as the expert by both themselves and their partners.

In some families, the mother had had past experience of handling babies which the father lacked. Carol (Int.11) came from a large family and had grown up with younger siblings and cousins and so was a relative expert:

“Yeah. His dad was a bit more em, I think he was a bit more scared of him at first because he’d never handled a tiny baby and he treated him like a china doll. But I knew what they were like.” (Int.11: 58-60)

Fathers therefore often embarked on parenthood with less prior contact with children than mothers and because of this lack of confidence and also because of breastfeeding and mothers not working, continued to spend less time than mothers caring for babies.

Mothers also gained experience and confidence in caring for their child when they were in hospital, and although fathers were free to spend time with their partner and child, it was always in the capacity of visitor. Jasmine and Stewart's (Int.2) child was born slightly prematurely and spent a week in the special care unit. Stewart recounted how during this time Jasmine became competent at caring for the baby, learning skills from the nurses and then passing on the knowledge to the father when they came home.

Jenny (Int.9) reckoned that in the early days she had been very possessive of the baby and had not allowed her partner to contribute much to his care. Now, as she reflected, she was finding that her partner took little to do with the child, who preferred to be cared for by his mother:

"You know it was eh just come in from work, too tired, he never really had the patience ... But when he got older and he'd given up his bottle and things like that Wayne just used to get all agitated. And maybe that was ma fault because maybe I should just have said well get on with it. And I feel as if I'm suffering now." (Int.9: 428-433)

This father typified the finding of Aldous (1998) and Gottman (1994) in responding to exclusion in the early days by not being interested in his child later on.

Some parents also said that the mother had spent time reading books, magazines and the comprehensive book on pregnancy and childcare given to all women early in pregnancy at the ante-natal clinic, especially as they had time to do so in the few weeks before the birth when they were on maternity leave. Thus mothers may adapt to their new role at a faster pace than fathers because greater preparation before the birth and greater involvement with their child in the early days.

Many parents attributed fathers' lack of involvement to their long working hours; in some cases fathers were doing voluntary overtime to compensate for the drop in

family income due to the mother giving up her work or reducing her hours, replicating the finding of Ferri and Smith (1996) that fathers who are sole breadwinners tend to work very long hours. Joyce (Int.7), whose husband was reported to be thrilled at becoming a father at the age of 45 years, said that he was disappointed at not being able to spend more time with their son. Joyce was due to go to visit her sister for a weekend soon and would be leaving her son in the care of his father, who was anxious about being in sole charge for the first time:

“Well, Norman works long hours. I mean there’s no two ways about it. I know he feels quite put out sometimes when Donald has done something new and he doesn’t see it and the way that he behaves at the Parent and Toddler Group. I’ll tell him a funny thing that happened and he’ll say ‘I miss all this, I never see this’. So he feels like second to me if you like and that’s why he’s a bit worried about letting me go away to my sister’s...Aye, but he doesn’t want me to go away longer than a weekend in case Donald misses me too much and he can’t cope.” (Int.7: 273-284)

Fathers who worked long hours were also described as being tired when they were at home, especially when they were in manual employment. In contrast, one father, who was a teacher and was home at half-past four most afternoons and had long holidays, appeared to be very involved with childcare. This highlights the way in which fathers’ involvement in childcare appears to be affected by their work patterns.

Analysis of the data therefore suggests that fathers’ transition to family life is slower than mothers’ and in many cases appears to be incomplete because of the factors outlined above.

As in Backett’s (1982) study, many parents emphasised that the father could carry out the full range of childcare duties although the mother was the main carer. Linda (Int.6) demonstrated this by stressing that when her husband was in charge of her son while she was working in the evenings he could manage to work out what to give him for tea if she forgot to leave instructions, implying that he was taking on a responsibility which was really hers. However, Sheila (FG2) was typical of mothers who worked part-time or were not in paid employment:

“At the end of the day, I’m sorry, I think it’s always the mother that takes the final responsibilities. It doesn’t matter what people say. If the father was at home with the child maybe it would be different, but eh...” (FG2: 548-551)

Some mothers talking about their partners in their absence were very critical of them. Elaine (Int.4) had split up with her partner because she felt that he had not taken on the responsibilities of a father:

“ Yes well, I’m 21 and he’s 22 but he’s really immature, and that’s one of the reasons that we split up, but I mean - he’s more like a big brother to her than he is a father. Even though he’s got a child.” (Int.4: 112-115)

Elaine, a young mother herself at 21 years, did not see her child’s father as being mature enough to cope with parenthood, and suggested that she was really involved with two children rather than sharing the responsibility of one child with another adult.

Some children were reported to prefer being with their mother rather than their father, and this could cause some tensions and make the mother feel tied down and the father rejected. Deirdre (Int.18) found that this situation resolved when they were on holiday and the father was with the child all the time:

RH - “Do you feel that she’s kind of your responsibility more than your husband’s?”

Deirdre - “Well I do because I’m the chief carer, yes. I like it when we go on holiday and it becomes very 50/50. Em but you know if Lucy. Lucy often when I’m around won’t let Philip do things. She’s fine with him if I go out of the house, but it’s really quite. Sometimes weekends can be actually quite stressful because we’re not having as nice a time as we should be having because she’s sort of rejecting Dad for Mum and I’m thinking why don’t you go to Dad? You’ve had me all week you know.” (Int.18: “234-243)

The imbalance between parents in caring for children because of fathers’ generally spending less time at home because of work commitments therefore appeared to be exacerbated by children’s preference for the mother because they were more familiar with her.

Eileen (FG4) described a typical scene of morning chaos when her three children, two of whom were at school, all came to her with various requests, while the father appeared to be oblivious to what was going on around him.

“My husband can get up and sit there and eat his breakfast and go out and not notice any of this going on. They don’t go to him they all come to me, usually at the same time” (FG4: 205-207)

However, both this mother and others referred to the fathers having a tendency to appear to be unaware of what was going on and then “erupting” (FG4: 299) or “losing the rag” (FG4:303).

Liz (FG3), whose husband was from the middle-east, gave her version of how she can kept control of their three children all day and then the situation got out of control when her husband comes home:

“You can be get along all day and he’s in the house five minutes and I almost feel like he’s taking over. I’ve managed to put up with their bad behaviour all day and I’ve managed to say “No, don’t,” you know and control it and whatever, and he’ll be in the door two minutes and everything’s in chaos, and the kids are all crying and I’m upset and we’re fighting and you know so you need to have a balance as well.” (FG3: 359-365)

While noting that these comments about fathers were all made by mothers in the absence of their partners, it seems that, from the mother’s perspective at least, fathers were less sensitive than mothers to children’s behaviour and reacted more aggressively when they became aware of children’s irritating conduct.

Both fathers and mothers reported that fathers played a significant role in discipline and in playing with children in a different way from mothers. In relation to discipline, fathers were considered by both mothers and fathers to have more authority, partly because they spent less time with their children and also because they have deeper voices and as one mother said “a certain aura” (Int.12:292). This replicates the findings of other studies e.g, Ferri and Smith (1996).

As found by Brannen et al (1995) and National Opinion Poll (1995), fathers were described as engaging in “rough and tumble” (FG6: 860) play with young children, having a “carry on” (Int.6: 256) and this was considered by both mothers and fathers

to be an important part of the fathering role, which was rarely provided by the mother.

Some parents of boys commented on the importance of fathers in both play and discipline, contributing to their son's upbringing in a way that mothers could not. This corroborates Aldous et al's (1998) finding that fathers do more with sons than with daughters. Although parents of girls also highlighted the role of fathers, the difference between mothers and fathers was less pronounced and there was more emphasis on sharing similar duties than on carrying out different tasks.

5.9 Mothers and paid employment

In exploring issues of relevance to contemporary parenthood, issues relating to women and employment were raised by parents who participated in the study, both in families where the mother was working outside the home and in situations where the mother was not in paid employment. As was found in the literature, fathers' paid employment was taken for granted, and was referred to mainly in relation to the degree to which it impinged on the time available to spend with children. However, many women, both those who were in paid employment and those who were not working, talked about work in relation to motherhood. Data analysis suggested that two main factors were of concern to women. Firstly, in families where both parents were working, parents talked about their feelings about their child being cared for by others and the perceived effects, positive or negative of this and of the alternative child care on the child. Secondly, parents reflected on the effects of working or not working on mothers.

Some mothers in the focus groups had worked after the birth of their first child but were not working at present because of the increased demands of having two or more children, and because of the increase in childcare costs involved; they were able to contrast their experience as working mothers with the present.

Effects on the child

Children who were at nursery or were looked after by a child-minder were considered by parents to benefit from the experience, getting them used to being with other children which would help them settle at nursery. Children attending nursery were considered by their parents to be educationally advantaged and developmentally advanced compared with other children because of stimulation they received at nursery. Louise and Gerry (Int.16), whose son attended nursery full-time had already decided to opt for private education, seeing this as a way of maintaining the educational advantage which they felt the nursery had given him. They also said that the financial implications of private education would be easier to contemplate because they were already used to paying an equivalent amount on nursery fees.

Effects on the mother

Many mothers said that they felt that work gave them a sense of individual identity; as Lorna (FG3), a nurse, said:

“...you are you and you’re nobody’s wife and nobody’s mother...” (FG3: 95-96)

Mothers talked about work providing space for themselves a chance “to get out the house and have time for myself” (Int.8: 119-120) and a “means of preserving my sanity” (Int.12: 883). Avril (Int.17), who worked in the evenings as a cleaner, appreciated some adult company and described work as respite from the demands of motherhood:

“I like it, it’s great because I’m talking to people and meeting people and it’s a break. Although I’m working it’s a break.” (Int.17: 523-525)

Linda (Int.6), who worked part-time and had extended family living locally, with a good network of both established and new friendships outside work, nevertheless found the social aspects of work important, and differentiated between work and other friends:

“... I’ve got friends at work and I’m in, I’ve just moved to a new team and it’s a really good team and you do get a kind of social life back again. I feel when you’re not working, nobody’s saying ‘oh, we’ve got a night out this night, do you want to come?’ apart from your friends who are mums and things like that as well.” (Int.6: 625-629)

Linda suggested that a night out with colleagues from work allowed her to socialise as an individual, while going out socially with other mothers involved her retaining her identity as a wife and mother. The comments of these three mothers suggested that being free of the status of motherhood appeared to be as important as being relieved of the duties associated with the role, giving them a different self-identity as well as different activities.

Eileen (FG4) described how when she went back to work after the birth of her first child the problems she was having with the baby appeared to resolve:

“Well, I found that before I went back to work I had great problems - with feeding and crying and that kind of thing. Once I was back at work the problems kind of diminished - I never really enjoyed that baby stage.” (FG4: 747-750)

Returning to work appeared to put the problems Eileen was experiencing with her baby into perspective, and her admission that she did not enjoy the early days may be interpreted as an acknowledgement that her baby’s behaviour did not change, but were seen by her as being less problematic once she was back at work .

Carol (Int.17) had been depressed, physically unwell and tired following the birth of her baby and was missing her large extended family who live in England; getting ready to go back to work had been the incentive for her to get into gear again:

“I can’t really pin it down, but I know when he was about 3 months old and I had to go back to work when he was 4 months old. I had to give myself a kick up the backside you know getting into a routine of getting up and I suppose that really changed me when I went back to work and I got company again.” (Int.11: 286-290)

Going back to work for Carol represented a return to having contact with other people after a period of isolation. However, she had not really enjoyed her work in the Civil Service before having her baby, and having her child had changed her values and perspectives; she had decided that “the rat race is just not for me” (Int.11: 327). Although she was very isolated socially, she enjoyed her caring role and had started to befriend someone with mental health problems with a view to possibly changing career to a more caring occupation. In contrast, three of the women who took part in one focus groups were nurses; although they enjoyed their jobs, they said that they felt that there was some overlap between their role at work and at home, as both involved caring, and did not benefit from the contrast between home and work roles from which other mothers benefited. For some mothers whose jobs involved caring, working did not represent as much as a contrast to family life as they might have liked at this stage of their lives, while for Carol, motherhood appeared to have triggered an interest in pursuing a career in a caring profession.

Some fathers who took part in interviews acknowledged the importance of work to their partners. However, some mothers interviewed on their own said that their partners did not understand the importance of work to them, and understood it only in terms of contributing to the family income.

Mothers referred to the need to keep up to date with current developments in their work, and “to keep in touch with the real world” (Int.11: 302).

Mothers in full-time paid employment

Four mothers were working full-time; of these three had partners who were working full-time, while the partner of the other woman was a full-time student.

All four women had been acutely aware of the impending return to work after their maternity leave, and described strategies for not becoming too accustomed to being at home. In particular, they had avoided establishing social networks with women who were not intending to return to work.

Catriona (Int.12), who knew she had to work full-time as her partner was a student, found being at home “a bit of a culture shock” (Int.12: 922). However, she found that for the first six months back at work she was “torn,” and thought about Toby when she was at work. She gradually learned to compartmentalise the two aspects of her life as she explained:

“It’s, you’re there to do your job, em, and I do switch off and I think you have to. I mean I don’t, unless, if he hasn’t been well or you know you’ll maybe phone the nursery or whatever, but apart from that I don’t really think about him until I’m coming home to pick him up again. You see you’ve got to switch off, on both sides. Whereas I could be more heavily involved in my work if I didn’t have Toby, but I don’t grudge that. Sometimes you think it’s as well I’ve got to pick him up or you’d be there all night.” (Int.12: 891-898)

As well as learning to keep her two roles separate, Catriona also suggested that having to finish work on time made her life more balanced, as she was unable to work extra hours.

Going back to work full-time after maternity leave was a time of considerable stress to mothers. Mothers had found the anticipation of having to leave home early in the morning with the baby caused anxiety, especially when during maternity leave they were often not organised till lunchtime. They also worried about being separated from the baby all day, and about what they would do if the child did not settle in the alternative care.

Louise (Int.16), although she had always intended going back to work, described her experience of the transition back to work:

Louise - “I hated it at first. Although I wanted to go back I absolutely hated the first week. I used to come home in tears and. But after that once I got into my routine. It was just so much hard work, getting up in the morning, getting organised because he was still sort of being fed every four hours.”

RH - “But what about now? Do you find it difficult to kind of work and...?”

Louise - "No I find it really quite easy now." (Int.16: 786-796)

The transition from maternity leave to full-time employment therefore represented a time of acute stress to mothers. The women working full-time expressed some ambivalence about their position, and expressed feelings of 'missing out' on some aspects of parenting. Mothers working full-time used their child's nursery staff or childminder as a source of advice in relation to parenting. They described a relentless round of long days, evenings spent preparing for the next day, weekends catching up and preparing for the following week, and limited contact with family and friends.

Mothers in part-time paid employment

Mothers who were working in part-time jobs said that they felt that they had the best of both worlds. They believed that they were able to combine the benefits of work with the more traditional aspects of family life. One woman (Int:11) who did not enjoy her job at all still felt that she benefited from some aspects of working.

Mothers described the importance of work in providing them with a sense of their own identity, rather than being a wife or mother. However, women working part-time were also involved in traditional activities, going to mother and toddler groups, meeting friends, and had a compartmentalised lifestyle, with two contrasting self-images. Mothers said that they enjoyed the combination of roles, and said that they had time to keep up with household chores and meet friends, and could also arrange clinic appointments and other engagements without having to take time off work. Families where the mother was working part-time also had more time to relax and enjoy the weekends together as a family, compared with the families where both parents were working full-time, where the weekends were described as being spent doing domestic chores and recovering from the stresses of one week while preparing for the next week.

Some mothers worked part-time while their partners were at home to look after children. This meant that there were no child-care costs or problems, but also meant that the mothers were missing time with their partners, and in many cases were

effectively doing two jobs, going out when their partner came home, to work in the evening or overnight.

Mothers talked about the benefits of having “a foot in the door” (Int.6: 620) and being able to keep in touch with developments at work. It was generally believed that it would be difficult to go back to work later if they gave up.

Dawn (Int.8) went back to work part-time because she was depressed. She described the benefits to both herself and her child:

“It’s a combination of us both getting time with people of our own age.” (Int.8: 138)

Mothers working part-time, whose children attended nursery, felt that their children also benefited from the combination of attending nursery and spending time with their mother.

Elaine (Int.4), who was working part-time, said that she thought that that full-time mothers should be offered help from the health visiting service “because they are seriously stressed out” (Int.4: 459), but felt that her part-time work protected her from stress.

Mothers who worked part-time also said that the break from the children made them appreciate them more than when they were with them all the time. Maureen (FG3) worked weekends as a nurse, and she reflected on how she felt after seeing little of her children for two days:

“Maureen - Oh yes, I think you appreciate your family when you go out to work. I mean I used to work shifts and em, and I really missed them like if I was doing like a late shift for example at the weekend, say 2-10, I didn’t see them, well Sunday morning and I was early the next day, and I didn’t see them say from 2 o’clock in the afternoon right till the next afternoon and I found that I appreciated them more, stuff like like” (FG3: 122-128)

Maureen therefore appeared to value her children more by having some time away from them.

Maggie (FG3) summed up the comments of many mothers who were positive about both their job and motherhood:

“Yes, well, I think I personally I think I’ve got the ideal working part-time. I would feel really frustrated if I was looking after kids all the time, but I’d also feel I was really missing out if you know, I didn’t have any time with my wee boy as well, I like the balance. I think I enjoy more both because I work part time.” (FG3: 112-116)

Maggie’s comment epitomises the sentiments of mothers who were working part-time about the equilibrium between childrearing and working they believed they had achieved.

Analysis of the data therefore suggests that mothers believe that they, their children and the family as a whole benefited from their part-time employment. Part-time employment appeared to protect mothers from isolation and stress, and enhance their enjoyment of their time spent caring for children, to allow children time with other children and alternative carers and thus to promote harmonious family relationships.

Mothers not in paid employment

Some mothers were not working, either by choice, or because their potential income after paying for child-care was not considered to be enough to make employment worthwhile. These mothers reflected on their position. Some mothers did not miss working because they had found their previous job very stressful, or because they enjoyed being with their child all the time. Mothers who were not working still needed to get a break from their children as Jackie (FG3) explained:

“I’ve got no desire to go out to work really. I’m quite happy, I mean sometimes I pull my hair out, but I never think ‘God, I’ve got to go out to work.’ I’ve got to get time on my own still and I’ve got to -I go round the shops or something like that, on a Saturday afternoon I go up the town by myself; I mean I still need the space, but I’ve no desire to go out to work.” (FG3: 152-157)

Jackie therefore felt, like the working mothers, that she had to have some respite from child care, and made a deliberate point of spending some time on her own at weekends.

Jackie explained how difficult she would find it to start working again now, with children of six and three years:

“I could go out to work, but I’d need to go to bed with my clothes on, I just couldn’t get them up and all in the morning. But then, it’s so long since I worked. It’s been like nearly seven years since I worked and I think if you’re used to doing it, that’s fine, but I don’t think I could go back to it.” (FG3: 133-138)

Jackie’s description of how she was now used to being a full-time mother and would find it difficult to organise the children and work contrasts with the comments of the women who prepared for going back to work full time after maternity leave by never adopting the slower pace of lifestyle associated with full-time motherhood.

Two mothers, who prior to the arrival of their first child had worked in menial jobs with no social benefits, said that they missed only the financial rewards of employment. For these women work was associated only with stress from which they were glad to be free.

Deirdre (Int.18), a teacher, had given up work partly because she felt that she could not cope with both paid employment and motherhood and also because she had been hoping to get pregnant again quickly (though she had had a miscarriage). She explained how she compensated for the aspects of her work which she missed:

Deirdre - “And I stopped working and the first year I wondered about that because I’d been working for so many years. But I just felt I couldn’t really cope. I didn’t want to have to cope with two big jobs. I wanted to do. Having got this far I wanted to enjoy it, you know. To me that meant dropping something that would have created a lot of pressure anyway, you know stress, which was full time work. And I think I’m. I am comfortable with that decision now. Though for the first year and half I think that sometimes I used to wonder whether it was just a bit of boredom that was making me a bit depressed,

because I didn't have enough stimulation in my life. But Lucy's providing that more now than she did when she was a baby.

I have to keep busy. If I don't that's when. If I see in the diary. I think it's because working full time I always had a very busy week. If I see the calendar's got, or the diaries got a lot of blank spaces in a week I have to do something about it quick otherwise I think I'm not going to get through this week. I like. And also living in a flat, and we're very quite outdoor people. I like to get out at least twice a day even if it's to play group or somewhere. Like this afternoon I'll just totter along to the post office to buy some vegetables and go to the swings. We've got to do something. Em occasionally we stay in but very rarely. And that's very important to me. It's for me as much as for Lucy..."

RH - "So are you quite busy even though you don't feel you have close friends?"

Deirdre - "Yeah I mean I do things, and I find that maybe it's the teacher in me. I'm starting to become the person that organises things. I have to be careful because after a while I sort of get a bit fed up if you feel that you've been put on, 'cause everybody sort of thinks that you're happy to do it. That sometimes you just want to get things moving or going. I run a play group on a Monday, a parent toddler group. Sometimes on a Thursday as well. It's ... down there, they need somebody else. And I found that was a good thing to do. It's not a lot, but it's eh it sort of fills the niche a bit of that sort of sense of identity that I had as a teacher I suppose working with people. Em I quite enjoy organising things. So I'm always sort of, got my feelers out for things like that. Em but em well so far in '98 it's been a pretty full diary, a lot going on." (Int.18: 279-309)

Although Deirdre was not working, many of the voluntary responsibilities she had assumed were very similar to those of her former job, organising and leading other people and having a structured timetable. By adopting a lifestyle similar to that of her previous job, Deirdre was able to replace some of the aspects of work she missed.

Jenny (Int:9) was not working and had very few social contacts and no close friends or family. She would have liked to work because:

"I'd like a bit of my independence back." (Int.9: 167-168)

Jenny had already described how she felt she was only a wife and mother, and so resuming work would have given her a feeling of being someone in her own right.

Mothers who were not working, but had the support of close family and friends, appeared happiest in their non-working role, while those who were not working and had no close support understandably felt very isolated.

Elaine (Int.4), who worked part-time, expressed some sympathy for full-time mothers:

“I think a lot of people who’ve got toddlers and don’t work and don’t do anything else, I think it’s quite heavy.” (Int.4: 455-457)

Looking after children full-time was therefore construed as being an unenviable option by Elaine.

Summary

Contemporary mothers in this study appeared to benefit from part-time work, while mothers from families where both parents work full-time described some tensions in their role. While this stemmed partly from the pressures on parents’ time and energy, parents also expressed some anxiety about being separated from their children. There was also a sense of feeling different among these parents, of not being the same as other mothers or the same as their own parents. It may be that if dual-earner families become more common, or as the children of dual-earner parents become parents themselves, the culture of childrearing will change to accommodate the needs of parents who have only weekends to spend with their children.

Many mothers who are not in paid employment appear to need respite from child care and involvement in activities similar which provide the stimulation and social support which working mothers derive from their employment. Work outside the home appears to provide an important source of social support to many mothers, and guarantees that women have some respite from childcare and a chance to have their own identity, which seem to enhance mothers’ ability to function in their role.

5.10 Introduction to social support and parenthood

The literature relating to social support suggests that social support is important in the lives of parents with young children. In this section, the role of family and friends in providing support to parents is examined, and the differences between these sources of social support explored.

5.11 The role of extended family in parents' lives

The analysis of the data in this study revealed that parents became more aware of their own family network after the addition of a new family member, both when they were near to kin and also when they were geographically remote from them.

Elaine (Int.4) had not had a good relationship with her mother whom she remembered as having been mean and controlling. However, the situation was now changed:

“Me and my mum we don't really , we've never really had a very good relationship but it's just since I had Chloe we've been getting on a lot better. But we don't really talk too much.”
(Int.4: 100-103)

The arrival of Elaine's child therefore appeared to have brought about an improvement in her relationship with her mother, even though they were still not close.

Jenny (Int.9), who was one of seven children brought up in poor circumstances, had talked about her own mother as being uncommunicative. She thought that her mother had been too tired to talk to her children, and that she herself had not initiated much communication with her mother because she had seen her mother as always being too tired or too busy to talk. Having her child had helped to build up the relationship again:

“ Oh no she's quite. She's really supportive, aha. I would say we were. Because I maybe am, maybe a wee bit more open than I used to be I think it helps. And ma mum is as well. Whereas ma mum was, well with ma dad. Ma mum went through the same

stages. She was in the house, stuck in aw the time, constantly every day and she just maybe was too tired you know. Was too exhausted to do anything or say anything.” (Int.9: 632-638)

Jenny appeared to develop an empathy with her mother from experiencing the demands of motherhood first hand, perhaps understanding for the first time what life had been like for her mother, and why she had not been communicative with her large family.

Barbara (Int.3) had not seen her father for some years, and although she still described him as “somebody we know, but not close family” (Int.3: 200), he had come up shortly after the birth to see his new grandchild and had subsequently kept in touch occasionally by telephone. The sense of kinship was therefore enhanced for both Barbara and her father by the new addition to the family, even though father and daughter still did not have a close relationship.

Two mothers who talked about feeling very isolated generally, were very aware of being far from family. Carol (Int.11) had a sister with children who lived surrounded by extended family, and her experience was the opposite of Carol’s. Carol, who had previously worked in a factory and was now employed in an office with higher pay and better conditions but with a more formal atmosphere, missed the camaraderie of her previous working environment. Coming from the country, she missed not only her family but the “quiet life” (Int.11: 337). She had also found it difficult to become involved in mother and toddlers’ groups. After Ben was born, she was very tired and took a long time to recover from the long and difficult labour. Carol compared her situation in the early days with that of her sister:

“Mmh. ‘Cause I couldn’t sit in the bath for 6 weeks and em I couldn’t pick him up when I was so exhausted. I was just lying in bed ‘til dinner time every day. Like he would. I would wake up and feed him and then he’d go back to sleep so I’d go back to sleep. Wake up, feed him, go back to sleep, wake up, feed him. And it was like lunch time and then you were getting up, rushing down to the shops and then you were in a right state ‘cause you can’t get your work done...And I didn’t really see anybody, so that was worse, ‘cause you know like. When my sister had her babies everybody popped round all the time would take them

you know, would take them for a walk and stuff. But I didn't have anybody like that I've never really. It's never bothered me before that I miss me family until I got. Until I had him....Yeah. I feel like he's missing out, because I've got a really big family. Lots of aunts and uncles and there's little em sort of cousins that are his age...I still feel isolated sometimes. I keep saying I want to go and live back near me mum." (Int.11: 88-129)

It seemed from what Carol said that she really could have had extensive family support but for her geographical isolation from her family, and her experience of parenthood would have been completely different from her present situation. There was a sense of Carol feeling that her son did not belong to her extended family because of their geographical remoteness.

Carol explained how her mother came up as much as possible and tried to make the most of her limited time by spending it all with Ben:

"So she comes up about 4 or 5 times a year and we go down about twice. So she does see him quite regular really. Because even though she maybe doesn't see him for six weeks or a couple of months or something, she gets to see him for a whole week. I mean she'll have him in her bedroom, sleeping in there. So she spends all day with him. So she sees him getting up and going to bed and getting his bath." (Int.11:589-595)

Carol therefore argued that although her mother had limited contact with Ben she compensated by being more involved with him when she was visiting than she would be if they lived nearby.

Deirdre (Int.18) was 42 years old, her husband is Australian. Her own mother lived in the south of England. Whereas Carol could imagine moving down beside her family and having a lifestyle which was precluded only because of geography, Deirdre missed what she could not never have. Her own mother was 70 years old and limited because of her age, and her family was scattered. Deirdre reflected on the problems of being far from extended family and of being older parents:

RH- "But if you lived where you'd come from and had family around would you imagine that being a lot easier?"

Deirdre- "Well I do miss not having family support, yeah. Not that I've got much family left, between us who are of an age to really sort of help out. Our families are both scattered, mine in particular...If we went and lived near my mum - I mean she's 70, so there's a limit to how much help she would be able to give us. We are thinking of trying to go to Australia for a year which would give me a bit of time round Paul's parents, but they're in their 70's as well. He's got a bigger family, sister and few brothers. Em that's been one of the biggest problems. Modern day life living miles away from your relatives. International relationships you know and we, and being older you know, we are we've missed out on that, having that extended family sort of thing." (Int.18: 339-358)

Deidre compared her own life with that of friends who have their family very near at hand:

"But yeah I, friends of mine we've got like friends coming up this weekend from down south, they've got. They always have family down the road and they just wheel their children down. And they just carry on with life, almost from day one of having a child. It was, says a lot for the extended family I think." Int.18: 370-374)

Thus Deirdre presented the contrast between her own "international relationships" and her friends' situation of having family nearby and being able to have children without the disruption which Deirdre and Philip had experienced. While Deirdre and Carol were similar in their acute awareness of lacking a family network, Carol was missing a potential reality, while Deirdre acknowledged that having a supportive family network was unattainable.

Barbara (Int.3) described how her brother now visited them more than before, even though he claimed not to like children, with the implication that he wanted to keep in touch with his nephew because he was a member of the family even though he did not enjoy children's company.

The transition to parenthood therefore appeared to create a sense of increased kinship among parents and their extended family; a feeling of belonging to a family was important to those who had family nearby and an acute awareness of isolation was

very evident among those whose families were remote. Relationships were strengthened and rekindled by the arrival of a child, and parents gained a better understanding of their own parents through the experience of having a child themselves.

While family networks were important to most parents, Jenny (Int.9), who was one of seven children, said that she liked to keep herself fairly isolated from her family because relationships among family members were fragile:

RH - "So you don't all meet up?"

Jenny - "No, no, no. In spite of being a big family everyone falls out with one another. You just need to say something wrong and you've stood on someone's toes. So I've just started keepin' away from them, from that. I mean dinnae get me wrong. It's nice ti see them and family being family. But when it gets. And there's times when you say... you know."
(Int.9: 233-238)

Although Jenny described becoming closer to her mother since having her child, she also preferred not to fraternise with them because of the repercussions that could follow, suggesting that perhaps a large extended family does not automatically guarantee a good supportive network.

Only Sharon (Int.1), who lived with her mother for a few months before moving to her own tenancy, gave the impression of being genuinely dependent on her mother for support and advice on parenting:

"Oh, aye, I couldn't have managed without her at the beginning. I mean my sister, she done it, she moved in on her own but she's just right round the corner from my mum. Although my mum's just up the road it's like, I couldnae do it on my own. I just couldnae. I wouldnae have took this house if I was on my own, I'd have waited for a hoose beside my mum. I would have had to. Because I'm a panic-merchant. But mind you I've actually calmed down. The first time he wisnae well, 'Mum, he's ill.'
"(Int.1: 217-224)

Sharon's mother continued to offer regular support when Sharon moved to her own tenancy nearby:

Sharon - "But the going out is quite good because we get a night out once a month together because my Mum takes him once a month, he stays at my Mum's house and we're getting to go on holiday to Blackpool this year because my Mum's going to take him for the weekend. Like she says 'I'll gie yous a break for the weekend, I'll take him if you want to go.'"

RH - "And do you see quite a lot of her anyway?"

Sharon - "I see her nearly every day."

RH - "Right. And does she ever look after him just for extra things if you wanted to go to town or something like that?"

Sharon - "Oh she'll do that, aye. She's good that way. Because, as I say, she did it for my sister so she's doing it for me." (Int.1: 116-128)

The literature review revealed that fathers who are involved with children in the early days are more likely to spend time with them later on, and it may be that grandparents who have shared the care and responsibility for children in the initial stages continue to take an active role in bringing up children.

Some grandparents were considered too old to be involved in caring for young children. In some cases this was linked to the age of the parents, being a natural consequence of the current trend for women to delay childbearing till their late thirties or beyond. In these situations parents often took the children to visit grandparents who played little part in their lives beyond this. June's (Int.9) mother had brought up seven children in difficult circumstances and Jenny described her mother as being old in relation to being 'worn out' rather than because of her age in years. Older grandparents, as well as being less fit, were said to have forgotten their own experience of bringing up children and to be outdated in their ideas. Grandmothers who had not breastfed were unable to provide support at a time when parents were often looking for help, and this was said by two mothers to have resulted in them deciding that their own mothers were not going to be a useful source of advice in the future even with other aspects of childcare. Some parents did not like to share anxieties with grandparents because they felt that it was unfair to worry them at this stage in the grandparents' lives.

In contrast to the families who had elderly grandparents, families who had younger, fitter grandparents often had limited contact because the grandparents were working and were pursuing their own leisure interests, which did not allow for much contact with grandchildren.

In families in which both parents worked full-time, parents said that they were too busy to have much contact with extended family. These parents also wanted to spend time with their child at weekends, and were not looking for time on their own. Catriona (Int.12) reflected that:

“ I just feel that working full-time the weekends are short enough without palming him off on someone else.” (Int.12: 146-147)

Louise and Gerry (Int.16) both worked full-time and liked to spend the rest of their time with Ruaridh. However, on the one occasion they had left Ruaridh for a short time with his maternal grandmother to allow them to attend a funeral, Lynn’s mother displayed her incompetence with coping with basic childcare:

“In the case of ma mum first time she tried ti dae a Pampers (disposable nappy). I mean we left her wi’ him for what an hour, something, we were going to a funeral. Aye we were going to a funeral and em left him at ma mums. Showed her how to do a Pampers and she’d done one years ago wi’ one of ma cousins kids but em by the time we came back you should have seen it and that. And it was a bit of a joke and she goes, ‘oh ah can’t handle this.’” (Int.16: 192-199)

Louise’s parents had had little opportunity to gain confidence in caring for Ruaridh, and were only approached to babysit for a short period to allow the parents to attend an important engagement. Babysitting in this context appeared to involve the grandparents ‘holding the fort’ for the parents rather than taking over complete care for the child, as Sharon’s mother did when she looked after her grandson regularly overnight and for weekends. Sharon saw her mother as an expert in child care, whereas Louise felt that she had to give her mother guidance on elementary aspects of looking after Ruaridh.

Most help by grandparents was considered limited, and not offered spontaneously. Many parents commented that grandparents would babysit if asked for specific reasons, but rarely volunteered. This gave parents the impression that grandparents did not really enjoy their grandchildren, but were merely doing it out of a sense of duty or to give parents a break. Tracey (Int.10) said that her parents would babysit “as a last resort, for short periods” (Int.10: 450). Catriona (Int.12) when asked about the grandparents’ involvement pointed out that:

“I feel that, whether its right or wrong, he’s our responsibility.”
(Int.12: 145-146)

There was an implication in this comment that the grandparents’ main reason for offering to look after their grandchild would be to provide parents with respite from their duties rather than to derive pleasure from spending time with their grandson. Catriona and Alastair (Int.12) explained the role her parents played in the family:

Catriona - “She’ll arrive like a person from the Red Cross coming with, you know, she’ll make soup, casseroles.”

Alastair - “Food parcels”

Catriona - “She’ll do this and she has her eyes about her. If they’ve come for the day and they’re having their tea she’ll bring half of it with them, you know, which...”

Alastair - “She always has done, before Toby, but more so after.”

Catriona- “Even more so.”

Alastair- “They tend to sense a problem and then they’ll be here doing things whether it’s wall-papering a room or whether they’ll take over the kitchen and just set to putting it in order whatever.” (Int.12: 1143-153)

Although Catriona appeared to have a close relationship with her mother, she did not seem to consider her parents to have any real bond with Toby, as she described:

RH- “What about your family?”

Catriona- "My parents are in Perth. I mean again if you phone they come through and they do come through regularly, but obviously it's to see us all it's not just to see Toby."

RH- "So it's just a social thing, they're not really coming to see Toby or do anything particularly?"

Catriona- "Yes, there's no-one else really. The grandparents really just visit, and Toby doesn't really know them that well."
(Int.12: 150-157)

It appears from the above dialogue that Catriona's parents were trying to support them by offering help in areas peripheral to childcare, such as decorating and providing meals, but were not involved in providing guidance and practical help with child care as might be expected in the traditional extended family.

Analysis of the data revealed that for many parents, both the responsibility for bringing up children and the practical aspects of childcare were assumed almost exclusively by the parents and that involvement by the extended family was very limited. However, some grandparents were involved with looking after children. In some cases this was while mothers were working part-time, while in one family (Int.6) each set of grandparents cared for the child on one day each, while he went to nursery one day. This was considered to be a way of giving the grandparents a chance to have regular contact with the child without imposing on them or interfering with their other interests, and also allowed the child to have time with other children.

Both parents whose own parents were involved with bringing up their children and those whose parents had little hands-on contact, talked about the importance of grandparents showing approval of parents' childrearing skills.

Maggie's (FG3) mother, while not providing practical support, showed her approval of Maggie's parenting skills:

"Well, I've got big sisters who are all a lot older than me with children, and my mum's very good as well, but she's great, she just lets me do what I want to do and she says 'Well done' or 'That's a good idea' or 'I did that' or something like that. She's very good that way." (FG3: 617-621)

Maggie was obviously encouraged by her mother's endorsement of her parenting skills.

Rosemary's (FG4) mother, who lived in Eire, and therefore only saw her grandson occasionally, seemed to approve of Rosemary's parenting and did not interfere, trying to be consistent with Rosemary's ways, rather than imposing her own.

"...actually they say a lot of positive things about how we're bringing him up in terms of what they see and even when he does all that she'll say "Well, he didn't do that when he was with me" but she doesn't actually criticise the way I handle it in fact to be fair - it's quite surprising really - she's never outwardly criticised anything we've done - and I think tried very hard to handle him in a way that she thinks I would, which is quite hard when I think she does have her own ideas and I could understand if she wanted to do things their way when he's with them - it's not a problem, obviously, when they're so far away."
(FG4: 447-456)

Rosemary had infrequent contact with her mother and was therefore in a situation which contrasts with Sharon (Int.1) who stayed very near her mother, saw her every day, and had spent the first few months with her after the birth of her son. Sharon had found her mother's support in the early days indispensable and this relationship may well have set the scene for ongoing advice and practical help in childcare subsequently. Rosemary's mother, because of her limited contact with her daughter, was not in a position to give day-to-day help and could only comment on her daughter's performance.

Linda's (Int.6) mother gave similar approval:

"My mum actually says 'You're doing a great job. I was never, I could never have coped with that, when I was your age.' She had her kids a lot older than me and she keeps saying 'You're doing a great job, you're doing a great job.'" (Int.6: 190-193)

Linda's morale was boosted by her mother believing that Linda was a better parent than she had been.

Neil's (FG5) description of his mother as a good source of help is inconsistent:

RH - "So can we just recap, if you have a problem with your child who would you normally ask?

- "My ma. I get a lot of help frae my ma, but no advice help because I've got different ideas aboot how my bairns should be brought up. When I hit my heid off the wall she says "Just get on wi' it". She'll no pat me or give me a wee bit of encouragement it's just "Get on with it. We had to, when we were young, we had to." But I try to explain to her that she was there wi' my dad, I'm on my ain with two with nae help, she doesnae understand that." (FG5: 533-543)

Neil's contradictory remarks suggest that his mother's approach gave him support simply by being there for him, even though she provided him with neither respite from caring for his children nor direct advice; this contrasts with Deirdre who had absolutely no family nearby and did not even have this positive feedback from grandparents which seemed to play a vital role in enhancing parents' self-esteem. Analysis of the data suggests that for some families with little contact with grandparents, not having approval from a trusted source may have had more of a negative impact on family functioning than did the absence of practical help and advice.

Parents reported that maternal grandmothers had more involvement with families than paternal grandmothers did. This may be because mothers were the main carers, and therefore tended to turn to their own mothers for support. Carol (Int.11), who was isolated and did not get any help, made the point that her in-laws did not offer help but might if she approached them. She differentiated between maternal and paternal grandparents:

"They would if I asked them but I don't like asking because it's not my side of the family." (Int.11: 146-147)

Alastair (Int.12), described the relationship between Catriona and her mother as intuitive, and her mother's attitude "proactive rather than reactive" (Int.12: 1116). He reflected on his impression of the difference between men and women as it concerned relationships with parents:

Catriona- "I think it's.. I've come to the conclusion that it's different between, I've seen it in umpteen marriages, the wife's parents. I think they're closer, a daughter I think is always closer than a son, although I hope that's not going to be the case."

Alastair- "I can see that."

Catriona- "But that's the feeling I get, whereas, you know, basically I'm told that I'm very like my mother. We think of the same things."

Alastair- "when you speak to her on the phone she picks things up without you having to say anything..?"

Catriona- "Well, there's that..."

Alastair- "It's uncanny really." (Int.12: 1126-1136)

Alastair appeared to accept that his wife's parents were closer to her than his own parents were with himself.

The tenuous relationship which some parents had with their parents-in-law was illustrated by Rosemary's (FG4) comments:

"My mother-in-law on the other hand - she's different - she wanted to look after him a couple of days a week when I went back to work and I thought "Over my dead body." That's happened because - she's a perfectly nice woman but very different from me." (FG4: 464-467)

Despite describing her mother-in-law as "a perfectly nice woman," Rosemary's true feelings appear towards her appear to be very negative in relation to involving her in caring for her child.

There was therefore a sense of maternal grandparents, especially maternal grandmothers, being more involved with families than the father's parents. However, the move to more egalitarian parenting between mothers and fathers may lead to an increased role for paternal grandparents.

As both Ciceroul (1973) and Douglas (1971) suggested almost thirty years ago, the social rules, in this case in relation to grandparenthood, appear to be changing. In the same way as attitudes to and images of fathers and working mothers lag behind the

changes in these roles for contemporary parents, so the role of grandparents for the study families appeared to have moved on from their more traditional image of being actively involved in advising on childrearing and helping with childcare. Grandparents were not seen by many parents as having a significant part to play in their family life, though their approval of parents' childrearing practices was important in enhancing parents' self-esteem. Barriers to involvement by grandparents appeared to include grandparents having many other interests, family life for many parents being very different from the way they had been brought up, and the older age of contemporary parents resulting in grandparents being relatively elderly and out of touch with childcare issues. Thus the social rules in relation to grandparenthood may be tending towards a diminishing role for them in the rearing of children.

Cornwell (1984) in her study found that mothers received more help from their own mothers than from sisters. In the present study, there appeared to be similarities and differences between grandparents and siblings regarding their associations with parents. Relationships with siblings mirrored those with grandparents in relation to their dependence on time constraints of other commitments, mainly regarding work, and on geographical proximity. Some families had very restricted time for seeing siblings, especially when mothers were working. Barbara (Int.3) explained that as she worked full-time during the day and her sister worked in the evening there was no time to meet during the week.

Susan (Int.5), whose parents and in-laws had all died before the birth of their child, had a very close relationship with her sister, who lived nearby and had children who were slightly older than Susan's. She used her sister as a source of reliable advice and compared notes with her. Other parents described a similar relationship with siblings and many women had frequent contact with sisters and sisters-in-law. Parents kept in touch by telephone, and analysis of the data suggests that it was easier for parents to discuss childcare issues with family of the same generation than with grandparents, when direct contact was limited. This may be due to the need for grandparents to spend time with children to trigger memories of past childcare

experience; sisters and brothers with children who were the same age or slightly older seemed to find it easier than grandparents to relate to parents' concerns when they did not spend much time with the families.

Sharon (Int.1) who had good support from her mother, also had frequent contact with her sister and her niece. She described how Keith was going to stay with her sister at her niece's instigation:

RH - "And does your sister help you as well?"

Sharon - "Aye, well he's staying with my sister on Sunday, it'll be the first time that he's stayed with her. She's watched him before but, because I'll be at the bowling and Johnny, his Dad, it's his other laddie's birthday and he always takes him out for his birthday and it's Lisa, like my niece, she went 'Auntie Joan, can he no stay with us.' And I says 'He can stay if he wants it's up to your mum.' She's always wanted him to stay at her house. Lisa spoils him rotten." (Int.1: 133-142)

Sharon appeared to be in a family network similar to those depicted nearly forty years ago by Newsom and Newsom (1963), with evidence of considerable help with childcare from her sister and niece. However, receiving practical help was very much the exception among the study participants. Nonetheless, most parents appeared to find it useful to share experiences with siblings and other family members of the same generation, who were often approached for advice and support in a more egalitarian and reciprocal relationship than they had with their own parents.

5.12 The role of friends in parents' lives

It has already been shown that becoming a parent represents a major transition for most people, and that for many parents support from the extended family was limited because of factors such as geography and changes in the culture of grandparenthood. Analysis of the data revealed that the transition to parenthood was often associated with a change in relationships with friends and in many cases a need for new ones.

From the data, it appears that relationships with friends were sometimes reassessed, and depending on how they fitted into the parents' new life some were reduced or

terminated, while others were strengthened. For the many parents who lacked family support, friends were often a substitute for family in fulfilling some roles. Many parents who had an active extended family network still valued friendships for a different type of relationship. Making new friendships during the transition to parenthood was important to many parents in establishing their new identity. The re-establishment and strengthening of previous relationships was common, for example after a chance encounter with previous school friends and work colleagues who now had children, and with neighbours who had been mere acquaintances in the past who also had children around the same time. Parents appeared eager to expand their social networks to include more people who had similar interests both past and current.

Friends fulfilled a variety of roles, depending on the needs and personality of individuals and of the children, and on the availability of other supports. Parents who were isolated were acutely aware of their lack of friends. Mothers talked about friendships with other women and with couples, while men who took part in interviews made little reference to friends they had in their own right. The male single parent did not mention friends at all in relation to social support.

For many parents, friends who were at the same stage of parenting as themselves were an important source of support. Shirley (FG1) summed up how she valued contact with other parents:

“It was good just to compare notes, have a good moan, and know that other people felt the same.” (FG1:332-333)

Elsbeth (FG1) described how friends could offer support:

“....we’re all good friends, we can talk and you know pull each other up and you know...We’re in the same position. We talk about what’s happening, and we’ve all got the same problems.” (FG1: 626-629)

Friends therefore helped parents to create a better sense of their own self-identity as parents, thus reassuring themselves that both they and their children were ‘normal.’ They also helped to improve parents’ self-esteem when they were going through a difficult phase.

For some women making new friendships was a very important aspect in the successful transition to parenthood. Isobel (FG1) described how she felt completely isolated before she started attending a mother and baby group:

“I went when Stephen was about 3 months old - I could have done with something right away, because I felt really cut off, and also I didn’t really know much about what to do with him.”
FG1: 314-316)

Christine (FG1) also expressed her need to establish new social contacts:

“My health visitor didn’t have a mother and baby group, that would have been life-saving. It was only by coming to the mother and toddlers’ group here I got to know other people. I was at home and was terrified. Here I was with this baby and I was terrified that he would die to be honest. I was petrified. There was no-one around except my mother-in-law and she was saying stop feeding him, get him on the bottle...it was only when <friend> pushed me out of the house and made me join in things and introduced me to other mothers I started to relax a bit and see that I could enjoy this.” (FG1: 343-355)

Christine and Isobel both indicated the vital role which other parents played in providing support and also in learning parenting skills.

Deirdre (Int.18), however, who was geographically remote from her family and old friends, reflected on how her new social network only partially fulfilled her need for social support:

“I like the feeling of being, not isolated. This is something...I know a lot of people through being a parent. But em it’s one thing knowing a lot of people. It’s another thing having sort of good friends, people you can really kind of connect with. Em so I am meeting lots of people which is great, but I don’t. I do feel a lack of sort of eh good friends. Most of mine aren’t in Scotland. We actually moved up here a few years ago. People I really want to talk to about the kind of things that are difficult to parenting you just feel like you’re just moaning away, if you don’t know them very well. So there is a sense of isolation in that respect sometimes. Em but then that was probably the case before we had Lucy, just from a sort of friendship point of view. Eh lots of friends but not those really close friendships. Although actually some are starting to form now.” (Int.18: 264-277)

In contrast, Eleanor (FG2) made a very definite distinction between the parents with whom she had contact on a day to day basis, and her established friends who were not easily accessible:

RH - "Eleanor, you said you were slightly older, did you find it easy to make friends?"

Eleanor - "Well before I suppose most of my friends were married couples with no children or were single, and out at work, so I suppose when we had the children, I didn't have any friends that I could go and visit during the day, during work-time, so I suppose it was really through Mother and Toddlers, and we didn't tend to do quite a lot anyway."

RH - "You got to know people that way?"

Eleanor - "Yes, though I still wouldn't call them close friends, they're people I might keep up with but they're not a big part of the children's circle I still have - we tend perhaps to have people to stay for the weekend and we would go and stay with people that we've known from years back." (FG2: 631-645)

Whereas Deirdre seemed to be trying to strengthen her relationship with new social contacts, Eleanor was keen to differentiate between day-time contacts which were almost akin to work colleagues, and her own established network of friends.

Louise (Int.16), whose son attended a full-time nursery, described how she had some contact with other parents at the nursery, even though it was brief:

"When you go up the nursery and that there's about three or four mothers there. I mean I'm up there for 8 o'clock because I start at half eight, and we all have a good blether and I think that's important, to speak to other people." (Int.16: 846-849)

This was Louise's only regular contact with other parents, apart from a few social events run by the nursery, which she and her partner also said that they appreciated. It was important that the parents with whom they discussed childrearing were also both working full-time, and therefore 'in the same boat' as themselves.

Joyce (Int.7) attributed the ease with which she could participate in groups to her previous experience as a community education worker. However, many mothers did

not find groups helpful in alleviating their isolation. Elspeth (FG2) described found she found it hard to integrate till she met someone she knew from the past:

“I did go to one, but it was difficult to settle in, but then a girl I knew from years back came, and then I made a point if someone new came, I made a point of going and speaking to them, because it’s so hard to get in. I’m not scared now about going into these groups, but initially I found it really hard.” (FG2: 654-658)

Carol (Int.18), who was very isolated, described her very negative experience of the mother and toddler’s group:

“I did em I went to the Toddler Group in (district) but I didn’t go ‘til he was about. I think he was about 9 months old em. And I found that they were really sort of cliquey. And there was only one or two that spoke to you. And then it’s on a Tuesday morning and I had to change my working days for a couple of weeks, so I didn’t go... I just felt I was sitting there by myself you know. I mean there was a couple of girls. I bumped into one of the girls that went there on the prom the other week and she asked me if I. She says why have you not been? I said well because it had been closed and because I had to change my days for a couple of weeks em. I said I don’t think I was getting anything out of it because... They came back really filthy and they were picking up bits of bread that other kids had eaten off the floor and drinking juice out of anybody’s cup. And it sort of put me off and because I didn’t feel that I was that welcome anyway I just didn’t really enjoy it.” (Int.11: 374-390)

Carol’s failed attempt to establish new social contacts at a time when she was feeling especially vulnerable were likely to increase her feelings of isolation, and exacerbate her depression.

Tracey (Int.10), expressed some wariness about sharing concerns with her closest friend about her partner because her friend was the girlfriend of Tracey’s partner’s brother and she felt that information was passed on and distorted among her friends and family. She explained:

“I’d maybe discuss it wi’ ma friends but...ma friend is going oot wi’ his brother. So the stories are getting passed roond in a circle just like. Ma friend’ll say stuff aboot his brother and ah’ll maybe agree wi’ her because ah don’t get on wi’ his brother too great

and that causes aggro between us two you know. So ah found, no it's pointless going talking to her because whatever ah say to her it gets passed on to his brother and then his brother relays it aw back it him and by the time it's come back to me there's bits missed oot and extra bits added you know." (Int.10: 805- 813)

Thus the negative side of a close social network, with relationships between family and friends was demonstrated by Tracey, who preferred to approach the health visitor for confidential and impartial support.

Analysis of the data therefore demonstrates the importance of friends to many parents, especially those without a close family network. Where family support was lacking, friends were seen as compensating for this to some degree, but most parents believed that their friends could never really substitute for absent family; likewise newly formed acquaintances could only partly make up for the absence of established friendships. Even parents who had good family support appeared to benefit from contact with friends because of the different role friends played in their life as parents. Parents who had very little social support appeared painfully aware of their isolation.

5.13 Introduction to the processes involved in learning parenting skills

It has already been shown that many parents had very little past experience of children and started out with scant or no knowledge of childrearing. During the focus groups and interviews, parents talked about how they learned the skills of parenting. Parents learned from their own experience and from the experience of family and friends. They also learned that each child was an individual and that their own unique understanding of their child was a vital factor in childrearing. Dealing with problems was deemed to be an integral part of childcare and provided opportunities for increasing parents' confidence in their role.

5.14 Learning from parents' own experience

Parents, as well as talking about turning to friends, family, professional sources and books as sources for advice in relation to parenting, often referred to the way in which their own experience had contributed to gaining parenting skills and to their

ability to cope with parenthood. Parents described learning “just by doing it and getting on with it” (Int.2: 68), by “finding my own way” (Int.17: 430) and by “working things out myself” (Int.4: 242).

Barbara (Int.3) explained how she built up her expertise:

“You know because it’s the first child and you’re not used to children you’re not sure what you can get away with or exactly what you should be doing. Like picking him up. Then it’s a case of just working out what works...I mean a lot of it was trial and error. It’s going to work or it’s not.” (Int.3: 853-860)

Barbara therefore learned her parenting skills by finding out for herself the strategies which were effective. However, children’s safety is likely to be compromised by this ‘trial and error’ approach to learning about childcare, especially when parents have had very little contact with children prior to having their own, as was often the case.

Parents said that they sometimes preferred to work things out by themselves, rather than depending on advice from others. Joyce (Int.7) was pleased that there was professional help available, but favoured using her own judgement:

“I mean, you don’t want too much. It’s nice to know they are there to give you the benefit of their experience and advice but you do want to be left to find out things for yourself.” (Int.7: 615-617)

Carol (Int.11) described how she modified advice according to her own experience:

“But then, I’ve not always stuck strictly to whatever the health visitor said or what the books have said. I tend to sort of use my own feelings or experience you know.” (Int’11: 553-555)

While Joyce gave the impression that she would try to find her own solutions to a problem first, before seeking professional advice only if her own efforts failed, Carol appeared to consider the views of experts and then modify them in the light of her own experience.

Parents described the anxiety surrounding the management of children when they were unwell, and how they learned how to cope with minor illnesses. Dawn (Int.8) reflected on how she no longer relied on professional advice when her son was unwell:

“Yeah, the first time I really panicked but he was ill last week and I knew what it was, so I knew what to do, I didn’t have to go rushing down to the clinic.” (Int.8: 33-35)

Dawn’s comment suggests that she had learned from experience to differentiate between minor ailments and more serious illnesses in her child. Parents appeared to make a decision regarding the perceived safety of learning from their own experience and could seek expert help or use a combination of advice and their own resources depending on their assessment of the situation.

Parents talked about how, as well as learning the skills of childcare, they had also learned to change their approach to parenthood. Linda (Int.6) reflected that she had persevered with breastfeeding more than she would second time round because she had been too idealistic in her goals:

“I was trying to be too good a mum at first ‘No, no, I’m going to feed him myself and it doesn’t matter if it’s every two hours and it doesn’t matter if he’s not sleeping at night, I’m just going to do this’ and as soon as I put him on a bottle at night he slept a lot better and although you want to do everything for your kids, you’re not wanting to run yourself down to the ground as well, but I would say that next time round I have obviously got more experience I would put them on to a bottle earlier. That’s just the way it is being a first time Mum.” (Int.6: 63-71)

Linda had apparently learned from her experience that she should balance her own well-being with that of her child, and that for her, bottlefeeding was a better option than breastfeeding overall. Other mothers who had eventually given up breastfeeding also said that they would not persevere with breastfeeding for so long with subsequent children if they were experiencing difficulties, because they did not feel that their child had been disadvantaged by being bottlefed and they had been exhausted trying to establish lactation.

Parents with one child mentioned that they would use the knowledge they had gained with subsequent children, and those with more than one child found that the skills they had learned with the first one could be used with subsequent children.

Eileen (FG4) had found that the health visitor’s advice not to take her baby into bed with her did not work with her unsettled baby, and she had eventually decided to

ignore the advice with good results; with the second and third children, she never tried to get the baby to settle in their cot and had learned that for her, taking the baby into bed was the best solution. As an experienced mother, she found that:

“usually now I can refer back to something similar that’s happened before and I feel more sure of what I’m doing now”
(FG4: 357-359)

Eileen had found her own experience more useful than professional advice in learning parenting skills that were appropriate for her situation, and she could now use her past experience. As well as learning about effective approaches to childcare, Eileen had also learned how to cope with the stress of motherhood:

RH - “Have you learned from each of the children?”

Eileen - “Em - I think I’m more able now to let things wash over me like I would have been a total nervous wreck if he had had 5 temper tantrums by nine o’clock in the morning like Melanie had today. I would have been at shouting and screaming pitch myself. Whereas all the time she was screaming I was hanging out the washing and saying to her you know “If you’re going to throw yourself on the grass, it’s very wet, I’d go inside and have a tantrum if I was you” and you know, “Give me another peg,” and “thanks very much,” and trying to ignore the fact of what she was doing and before I couldn’t do that. It took me a long time to ignore the fact that she’s screaming. It didn’t work - I mean she still had five.”

RH - “Do you think you’re thinking oh well she’ll grow out of it anyway, or is it a different way of handling it?”

Eileen - “No it’s partly self-preservation. I’ve discovered that if I let them especially if they all start at me - if I let them really wind me up, and they do sometimes, if I just - I’m the one that gets affected by it, not them. But I have to sometimes be able somehow to distance myself and not be too hurt when they’re horrible to me. I mean there are times when I get up in the morning and I just feel that everybody is getting at me. Why isn’t my favourite tee-shirt clean. I want this, I’ve no socks, where’s my lunch, I don’t like that sandwich - and by half past eight I feel like a totally useless mother. My husband can get up and sit there and eat his breakfast and go out and not notice any of this going on. They don’t go to him, they all come to me, usually at the same time with horrendous problems of not having

done their homework, or needing this or needing money and I have to work on myself and have to try to stay calm, sometimes I manage it and sometimes I don't." (FG4 179- 206)

Learning to cope with the emotional demands of parenthood was therefore an important part of learning to be a parent.

Learning from their own experience seemed to be important for parents in acquiring childrearing skills, and some skills could only be acquired this way.

5.15 Learning from others

While parents learned many of their skills by their own experience, they also talked about the part played by others, mainly family and friends, in this respect.

Grandparents and parents' own siblings were the main sources of advice for parents within the extended family. Parents learned about parenting from family in two ways: directly, by observing the way in which family members behaved with their own children or with the parents' children and indirectly, by receiving advice from relatives based on their experience of bringing up children.

Grandparents and others from the previous generation

Some grandparents who were geographically near and had frequent contact with families were seen as good sources of advice. In particular, grandparents who were actively involved in caring for children, for example while parents were working, were often viewed as valuable sources of help with parenting. This may have been because those grandparents gained credibility, by providing practical care. Also, spending time as sole carers of children may have enhanced grandparents' recollections of their children at the same stage of development as their grandchildren, resulting in them being able to give more relevant advice to parents than those with limited contact could provide.

Some parents said that while they considered their own parents' ideas on childrearing outdated, they nevertheless approached grandmothers for advice about medical problems. While Eileen (FG4) was disparaging about her mother's approach to aspects of childrearing such as discipline, she approached her for advice about

children's ailments and minor accidents. Linda (Int.6) also regarded her mother's general ideas outdated, but when Edward was ill with a temperature and vomiting she appreciated her mother's advice about managing him, and accepted her reassurance that he was not dehydrated. Jasmine's mother (Int.2) lived some distance away and had little day-to-day contact with the family. Jasmine thought that her mother was out of touch generally with childcare issues but that her mother's recall of specific incidents such as her own and her siblings' childhood illnesses was probably more accurate than her recollections of more general issues.

Parents' increased willingness to accept the advice of grandparents in relation to childrens' illnesses may have been because they did not believe ideas about the management of illness to have changed so much as those about other aspects of childcare. In addition they may have been more receptive to advice when they were anxious about their child's health and were looking for direct guidance at a time when a trial and error approach was considered to be inappropriate or positively dangerous.

Some parents described scenarios where they learned how to handle situations, such as babies crying or toddler tantrums, by observing the way their own mothers handled their child. Elspeth (FG2) described how her mother could manage her children, especially her older one who had some emotional problems:

Elspeth - "Well, I was one of three, but we were girls and I've got two boys, and she just had, particularly with my older one, such a knack with them. And she can get the two to respond to her in a way I can't."

RH - "So you would go to her if you had not a medical problem, but just because you were worried about their behaviour that kind of thing?"

Elspeth - "I usually talk it through with her first. Yes, I do."
(FG2: 256-263)

Her mother also managed to toilet-train her older boy while Elspeth was in hospital having her second baby, after Elspeth had been trying to do so for some time. Elspeth therefore learned from her mother's advice and from seeing her handling her

children. This grandmother had credibility in her daughter's eyes, and Elspeth also thought that her mother had an insight into her children because she could recognise traits they shared with Elspeth and her sisters, such as a tendency to prefer to play by themselves rather than with other children.

Some parents considered their own parents' experience to be outdated. They also sometimes thought that grandparents had forgotten their parenting knowledge or had distorted recollections because of the length of time that has elapsed since they had used the skills.

Linda described how she did not expect her mother to remember about her experience:

"I think it's really difficult for your mum because she'll kind of forget what it was like as well. I mean you're talking 27 years ago...and a lot of things have changed since my mum had us."
(Int.6: 195-224)

Cheryl's mother-in-law (FG5) did try to give her advice but according to Cheryl, her ideas were not relevant to contemporary parents:

"I wouldn't go to my mother-in-law or my mother because I'm 29, my mother and mother-in-law are in their 60's and to me that's a couple of generations away and things were just done that different then. My mother did just try once, giving me advice, but I just found that it was just something out of the dark ages." (FG5: 402-406)

Isobel (FG1) described why she considered grandparents' experience of childrearing to have little relevance:

"I think the whole thing about children has just turned on its head since our parents did it. Most of the things that grannies say these days is just the reverse of the thinking nowadays - the smacking as a form of discipline, and having to be in bed at half-past six. You know, very regimented the four hour feeds and not picking the baby up in between." (FG1: 183-188)

Thus these three mothers considered that childrearing skills change over time, and that it is important to seek advice from up-to-date sources.

Eileen (FG4) described how her mother acknowledged that her ideas were outdated, but still said what she would do in various circumstances:

“See my mother’s really good. She doesn’t say things to me personally. She says things like things have changed. She’ll say things like you know ‘I would do that, I know that’s old-fashioned, that’s not how you do it now.’ “ (FG4: 473-476)

Previously, Eileen had given an example of the contrast between her approach and that of her mother, in relation to discipline:

“Well, my mother thinks I’m far too soft with them. She thinks they should just be told and that’s that and none of this negotiation and em talking to them, and backing down and letting them talk me into something.” (FG4: 158-12)

The above quotes suggest that Eileen’s mother considered her more traditional approach to discipline to be better than Eileen’s but realised that attitudes to children had changed as discussed in the review of the literature (see Chapter 2.2 pp9-13).

Catriona (Int.12) described her mother’s exhortations to start toilet-training early.

“Well I remember when he was year old it was the usual ‘he should be on a potty by now, instead of being in nappies. If you had to wash the nappies you’d have him out of nappies by now.’ I just ignored her.” (Int.12: 1163-1166)

Catriona and other parents questioned whether their own parent’s recollections were accurate, especially in relation to the age at which children had achieved milestones, such as sleeping through the night and being toilet-trained.

Grandparents who were considered to be incompetent in relation to providing help with childcare were also, understandably, not approached for advice about parenting issues. For example, Louise (Int.16), who was reluctant to leave her child with her parents as they seemed to have forgotten how to care for a young child (see section 5.11 p162), said that she would never approach them for advice for the same reason.

Lorraine (FG5), although she herself had her first child at the age of 16 years, described how she felt that she and her siblings were more knowledgeable about childcare issues than her mother:

“Actually, my mother had 3 children by the time she was 20 and it was a case of she still basically learning because there’s stuff she still doesn’t know. And even about children’s bringing up there’s things we’re telling her that basically she didn’t know.” (PFFG CH1: 412-415)

While some parents believed their own parents were out of touch with childcare matters, this grandmother was considered to have been too immature when a mother of young children for her views to have any credibility in her daughter’s eyes, even though she had the benefit of having very recent experience of bringing up children.

Some parents described how their own parents tried to avoid passing on their own experience, and encouraged them to work things out for themselves. In one case this was because the grandmother felt that her own mother and mother-in-law had pushed unwanted advice on her about how to bring up her own children and had undermined her confidence, and she was anxious not to do the same with her own daughter. Dawn’s (Int.8) mother encouraged her daughter to work things out for herself:

“She’s given me some ideas but she says to me ‘You’ve got to sort it out for yourself,’ you’ve got to do what you think is best for you.” (Int.8: 279-281)

Elsbeth’s (FG2) mother-in-law was also reluctant to impose her view on Elspeth:

“My mother-in-law always said to me ‘You make what you believe to be the right decision at the time, take advice if you like, but it’s your decision.’” (FG2: 524-526)

Thus some grandparents appeared to believe that parents are solely responsible for decisions relating to children and did not consider themselves to be important sources of advice.

Some parents, especially those who had had experience of children, said that they did not need advice from family. Carol (Int.11) did not feel that she needed advice from her mother:

RH “What about your mother? Do you ask her for advice?”

Carol- “My mother? I tell her what’s going on but I think I’m managing fairly well really...I think I’m pretty much my own judge really.” (Int.11: 564-569)

Likewise Catriona, whose sister had a child slightly older than Catriona's, did not consider her to be a source of advice:

"I wouldn't phone specifically to ask for advice I don't think. It would maybe come up in the conversation." (Int.12: 358-369)

Some parents commented that they ignored gratuitous advice. Dawn (Int.8) described how her aunt was always trying to tell her what to do, and as a result she rejected the advice as a matter of principle, even though it may have been quite sound:

"Because if my auntie tells me something, I'll just ignore it. It could be the best advice in the world but because she's trying to push it on me and say that her way's the way it's got to be, I won't do it." (Int.8: 281-284)

Sheila (FG2) also ignored unsolicited advice:

Sheila- "...so my mum - I tell her things but I never listen to her advice."

RH- "Does she try to give you advice?"

Sheila- "Oh yeah, but I just ignore it." (FG2: 290-293)

Thus some parents made it clear that they did not see the previous generation as having a part to play in advising them about parenting issues, and indeed Sheila appeared to see it as an intrusion. Carol, Catriona and Sheila did not have family nearby; parents with frequent contact seemed to be more receptive to advice from family than those whose extended family was geographically remote, and who therefore had less contact with them.

Family of the same generation

Parents who had a sibling with children of a similar age or slightly older talked about the important role they played, especially when they were geographically close and had frequent contact. Although fathers did refer to discussing childcare issues with their brothers and sisters, in most cases it was mothers who talked to their sisters or sisters-in-law. For many parents in this position their sibling or sibling-in-law was their main source of advice and their experience was considered important. Two mothers had sisters with children very slightly older than their own. Susan (Int.5) had

a sister whose child was just three months older than Susan's and this was seen as a considerable benefit :

"My sister had a baby three months before us, so she was actually a big help, you know, because any problems I was coming across, she had usually just encountered sort of thing...The first child just three months ahead, it was just right. She was just moving on to a stage I could see, or she could tell me." (Int.5: 50-52, 448-451)

This situation allowed Susan to benefit in two ways, firstly by having a 'preview' of the stage of development her own child was about to reach, and secondly by having a source of up-to-date advice, based on recent experience of topics such as weaning.

Parents also commented that they found their siblings particularly useful because they shared the same background and values and also because their children were likely to have some common traits. This was illustrated by Sarah (Int.9) whose sister, who had three children, and mother were living nearby: the combined advice and experience of her mother, who had brought up four children and sister, whose ideas were seen as a more modern version of those of her mother's, were considered by Sarah to represent the ideal combination of sources of advice. However, not all advice from family members of the same generation was considered useful. Emma (Int.14) felt that her sister-in-law's ideas were already dated:

"I mean I cannae really talk to my sister-in-law because her children are bigger now. She did things different to what ah do, so I wouldnae really ask her." (Int.14: 578-581)

Emma gave the impression that she considered parenting advice to become dated relatively quickly.

Parents also said that they learned how not to bring up children, by observing the results of their siblings' endeavours, as Barbara and Steven described:

Barbara- "I think we picked up more from my nieces and nephews about what we, well what I don't want. Like my wee nephew Toby, he's the only other boy within the nieces and nephews and I think, if Martin turns out like I'll skin you alive, pal. Toby's very.. yes."

RH- "Very what?"

Steven- "Very forward"

Barbara- "It's a case of 'I want', not 'can I have?', it's 'I want'. If you say 'no' or 'I've not got anything for you' that isn't quite enough for him, he wants." (Int.3: 344-353)

Barbara and Steven were making a conscious effort to avoid using the approach to childrearing which Barbara's brother and his partner had used. Parents therefore modelled their behaviour on that of others whose strategies they admired and also took heed of children whose conduct they did not want to see replicated in their own children.

Friends with children of the same age

The importance of social networks of parents with children of a similar age has already been discussed. These social networks, as well as being important for providing mutual support, also provided a forum for parents to learn parenting skills by discussing and sharing experiences about bringing up children.

Jasmine (Int.2) kept in touch with other mothers from her ante-natal class and found that:

"although we've probably got around the same knowledge, they might know something different." (Int.2 371-372)

Linda (Int.6) also found other parents to be a good source of knowledge:

"I think you learn a lot, although maybe you don't realise it at the time, from talking to other mums." (Int.6: 104-105)

Catriona (Int.12) expressed the same sentiments:

"Uh-huh I think that was good just to hear other points of view and get ideas for different things, suggestions." (Int.12:376-377)

Thus parents learned by mutual exchange of knowledge with parents with a similar level of knowledge.

Isobel (FG1) was very isolated with no friends and family around in the early days. She started going to a mother and baby group when the baby was three months old and found that as well as gaining social support she learned an enormous amount from discussion with other mothers, as before she "did not know much about what to

do with him” (FG1: 316). Isobel therefore acknowledged the importance of interacting with other parents in enhancing her parenting skills.

The importance of mutual exchange of ideas with parents at a similar stage was associated with a recognition that there is no one way to approach childrearing; there was also a feeling that other parents at the same stage understood the stage that the children had reached better than those whose children were older. Comparing notes with other parents was also seen as more helpful than being given direct advice about how to tackle a problem, and Linda’s comment suggests that she believed she was learning more by pooling her ideas and experiences with those of other parents rather than being given direct advice by someone ascribed the expert role. The relationships with parents at a similar stage may have been more equal and less emotionally loaded than with grandparents and parents, especially from the extended family, of older children.

Learning from parents with older children

Parents sometimes learned parenting skills from friends with older children. The advantage of this was said to be being able to see how the children had turned out, which influenced the decision about whether or not to follow the advice or example of these parents. The parents of older children themselves were also assessed in deciding whether to follow their advice or example.

Jasmine (Int.2) asked her friend at work who had two older children because:

“..she has come across as being very calm and always seems to know what she’s doing.” (Int.2: 353-354)

Thus Jasmine approached her friend on the basis of her apparent competence in the parenting role.

Mandy (FG5) trusted the advice of friends whose children she considered to have turned out well. She was worried about using controlled crying to manage her child’s refusal to go to bed in case it caused her child psychological damage, but when a friend said that she had used it successfully with her older child whom Mandy could see had suffered no ill-effects from such a regime, she felt that it was safe to do so.

Other parents commented that they had seen the results of what they perceived as poor parenting, for example children who stayed up late at night, and had resolved to ensure that they did not adopt this approach.

Friends with older children could also reassure parents that their child's behaviour was just a normal phase of development which the older children had gone through, and parents said that they could see that the older children had indeed turned out all right despite having displayed the same behaviour when they were younger.

Deirdre (Int.18), who was keen not to copy the style of parenting to which she was subjected, used friends whom she judged to be good parents as role models:

RH- "So what helps you in learning about parenting?"

Deirdre- "Em I do have some friends who I see as sort of role models and I think that helps, if you've somebody who you sort of think. Well I really like the way they bring up their children and I really like the way their children are, as a result of that kind of interactive type of thing. That is the sort of way I'd like, love to be for us, you know. That, that can be quite a strong factor I think in a way. Because you can read any amount of books but em. It's finding ,you know, a way that fits in with everybody in the family. There's compromises going to be made, but I don't feel that we should compromise ourselves totally. So em good parents whatever, em."

RH- "So do you tend to see what they're doing or ask them what they've done or?"

Deirdre- "No I just observe the way they are with the children. The way they talk to them particularly."

RH- "These are people in Edinburgh you mean?"

Deirdre- "No actually they're not, they're friends, friends that em are coming up this week. Their children are older but I've known them since they were babies. And they are delightful children. They have a very straight forward simple sort of ecologically sound kind of life you know. But they just have such an appreciation of. They're also very bright which is something you can't create necessarily. You can only provide the opportunity for developing their potential. But em I just think they, they just have a very nice life as a family, they don't sort of let things put them off. They don't sort of see obstacles to

doing things. They look at how they can do something as a family rather than saying oh we can't do that any more because we've got the children or whatever. It's a case of right this is what we used to do. This is what we like doing. How are we gonna do it with 4 of us? And I just think that's a good attitude because it keeps everybody happy."

RH - "Do they know that they're your role model?"

Deirdre - "Em no not as such. It's something that's sort of old, time spent with them. But we have, we have. You know they sort of said to us we think Lucy's great. She seems to be really nice, the way you sort of relate to her and that kind of thing. So they. You know they sort of. And I may have said well you know we learnt our lessons from you or something like that in casual conversation. But we're not very good at saying things like that, are we?" (Int.18: 616-556)

Deirdre had learned more from the philosophy of this family than from more precise details of how the parents managed their children, and was trying to create the same ethos within her own family, by modelling her general approach to family life on that of her friends.

Deirdre acknowledged that replicating other parents' approach does not guarantee success, and much depends on the child's personality and innate intelligence. Deirdre liked the way the whole family operated, the family dynamics, and the way they approached situations so that the family could do things together.

Earlier in the interview, Deirdre had talked about how the same parents had avoided using physical punishment, and had used their own experience as children as a model for parenting their own children:

"Yes. The discipline side we haven't talked about too much. I have discussed it with other friends whose children have gone beyond that stage. We've talked about the smacking issue. Em I think it was in the papers at the time. And it's really interesting because like one of my friends, his mum she's a Relate counsellor, that never smacked them, and they've never their children. I mean they all seem fine to me you know. Em it's very difficult I think. And I always think has it been much easier for them because they've got the support from their own upbringing and they've got the experience from their own upbringing. Is it easier for them? They're able to have

confidence... So in some ways I think, well you know you should be able to break cycles, but sometimes you need the information and knowledge in order to do that. (Int.18: 524-536)

Deirdre appeared to be very aware that while she was going to have to make a conscious effort to learn ways of managing her child which did not involve the harsh discipline to which she had been subjected as a child, her friends had learned this approach from their own upbringing and therefore had the advantage of having very good role models. While Deirdre was consciously seeking models on which to base her own approach, she recognised that her friends' experience of being brought up in what Deirdre saw as a happy and effective family provided them with an optimum background against which to bring up their own children.

Some parents felt that parents of older children had forgotten what it was like when their children were younger, and that their advice was of little use. Parents of older children were perceived as being more prescriptive in their approach to advice giving and were described as "trying to tell me how to bring up my child," (FG3: 821-822) whereas parents of children of the same age were described as sharing and comparing experiences which could be used, modified or rejected. Parents of older children were used as models and parents appeared to appreciate advice from these models when actively sought, but not when unsolicited, when it could be construed as intrusive and an attempt to undermine parents' confidence.

Dual-earner families and learning parenting skills

The four families where both parents worked full-time had little contact with family and friends. One relied on the nursery staff for advice, and one learned from her child-minder; in each case the mothers felt that they benefited from the fact that the people giving advice knew the child concerned and also had extensive experience of many other children.

Rosemary (FG4) described how she approached her friends who were not working for advice on parenting, partly because these parents spent more time with their own children and were therefore more experienced parents than she was, and also because they were mixing with other parents socially. When Craig started biting, she did not

know if this was a major behavioural problem or just a normal aggressive phase of being a toddler. As well as wanting to know about other parents' experience of dealing with a problem, she learned that it was common at Craig's stage of development:

"I go to friends who don't work, funnily enough, because they have a lot more experience than we do because they are with their children all the time, so when I was working full-time and Craig was biting children and I thought I had the child from hell and I phoned up this particular friend and she said, 'Gosh, no, they all go through that, they all go through a biting phase or whatever,' and I got huge relaxation from that. She says it's just because you don't go to toddler group you don't see it or whatever. And then she would tell me that her friends at the NCT discussed it and that what they were doing was that so I tend to go to people who are with their children more." (FG4: 318-328)

Parents who did not work full-time, and who had a network of friends with children of a similar age, suggested that for parents who work full-time and who therefore did not have access to these informal sources of help, parenting classes might to some degree be a substitute for this experiential learning.

5.16 Limitations of advice from family and friends

Although parents described how they had learned parenting skills from family and friends, some also expressed reservations about the advice they had followed:

Elsbeth (FG2) whose older child had emotional difficulties, wondered if she would have been better following her own instinct rather than following the advice she was given:

"Also I think I enjoyed the baby stage with number 2 better than first time around, you know. People say, don't spoil it, you know, and you listen. The second time around I remember sitting cuddling my baby, probably bonding better with my baby even though I had a section, but it was really a less traumatic delivery than with John. It took me a long time to bond with John, and I sometimes go back to that and think oh dear, is that where I've gone wrong, and then I have to say to myself 'No you didn't go wrong.' It's just the way it was for him. And I love him just as much as I do Jamie but I'm perhaps more - I

find it easier to be openly affectionate with Jamie than I do with John. (FG2: 215-225)

Elsbeth's comment suggests that she was more self-confident in her own judgement with her second child than she was first time round.

Some parents found that other parents had not experienced the same situations as themselves and were therefore unable to give them advice; this was often a trigger for seeking professional advice.

In the same way that many parents considered the advice of others to be of limited help, some also commented that they could only advise other parents to a certain degree. Eileen and Rosemary (FG4) discussed the limitations of the advice they might give to other parents:

RH - "Do you feel confident about advising other parents, now that you have three, Eileen?"

Eileen - "I can't really tell somebody else. It's not really advice - I can't really tell somebody else what they should do, all you can do is tell them what you've done, and give them the sort of the pros and cons because all the things that you do, there are things that work and things that don't work."

Rosemary - "And also things that work, for one child don't work for another. But I've done it. I mean I've sat there with a friend who has a child who's a year younger who's got terrible sleep problems and she works full-time as well and she was always saying 'Aw, he's teething and this, that and the other,' and I would sympathise but inside I would be thinking 'Oh my goodness, I wouldn't have that' and somebody recently somebody told me about someone who had 5 children a friend of my mothers and the first four she had all the rules. You go to bed, and anything I've done has worked, and with this one, it just doesn't work. This child just doesn't sleep and that's all there is to it and this woman says, 'if anyone said that this might have happened to me - I just wouldn't have believed it except that it's happened to me and this has really changed my way of thinking.' So I would tell someone what I've done, but I'd much less kind of look down on someone who's got a two year old and it's not working for them. Because some children some things will never work even though they worked for somebody else." (FG4: 569-595)

Eileen, who had three children aged from three to teenage, reflected that although she could pass on her experience to other parents and could tell them what had and had not worked for her, she could not give them explicit advice about what would work for their individual child. Rosemary was also cautious about giving advice because of the experience of someone who thought that she could enforce bedtime on children until she had her fifth child, demonstrating to Rosemary that a blanket approach to childcare does not work. Parents who recognise the limitations of their own advice also seem likely to have reservations about using the advice of others.

While parents found learning from family and friends important, for some parents these sources of advice were seen as substituting amateur help for professional advice.

Iris (FG1) described how the professional advice on parenting takes place antenatally, and is focused on labour and the birth:

“I think the parenting classes, well certainly the ones I went to, everything was focused on the pregnancy, labour and then suddenly it all stops, in terms of actual classes and things and then the only thing I got in that direction was from the mother and baby group, and meeting other mothers who were at the same stage sort of thing.” (FG1: 81-86)

The above comment implied that this mother would have preferred to have more professional help with parenting after the birth of her child.

Deirdre (Int.18), whose health visitor ran a post-natal support group, and who had had considerable support from her health visitor, said that she inferred that the health visitor expected parents to become more self-sufficient after the group had finished meeting, and that at that point she had had to turn to friends for advice, although she would have liked more professional advice.

These typical views gave the impression that professional sources of parenting advice were important to some parents and that they considered lay sources of help complementary to, rather than a substitute, for professional interventions.

5.17 Parents' understanding of their child and learning parenting skills

While parents learned from their own and other's experience, a vital component of learning to be a parent was said to be 'getting to know' children. In the early days, parents looked for advice from sources perceived as expert: family, friends, professionals and books. However, as time passed, parents realised that they had a knowledge of their child which nobody else could have and were "tuned in" (FG2:421) to their child; parents therefore felt that they had to modify advice to suit the individual child's personality and circumstances. This sentiment was reinforced when parents were looking after other children, and realised that they were unable to interpret other children's needs in the same way as they could when dealing with their own children.

Parents' understanding of their child was facilitated by the child's increased ability to communicate with them, and also by being able to see their own personalities in their children, and recalling how they were as children. Elspeth (FG2), whose child did not socialise easily with other children, reflected on the similarities between herself and her son:

"Well, my older one's a challenge. I think probably because he's too like me (laughter). And yet he's very like his dad, I think the things you don't like in your children are things you see in yourself that you don't like. And although they're people in their own right, that's the biggest lesson you learn about being a parent, also that you recognise things in your children that are like what you were like when you were a child, for example, I wish John would socialise more, with his peer group, but he's more at home with older and younger people, and I know that's how I was when I was a child, and I get quite uptight about that, because I know I found it quite hard to socialise until my late teens." (FG2: 192-202)

This child had been assessed by his nursery teacher, health visitor, general practitioner and psychologist because of behaviour problems, and Elspeth expressed the view that as parents, she and her partner had to make the final decisions about his management:

“We’ve learned to ask different people’s advice but at the end of the day it’s our child and we’re the only people who really know him and can decide the best course.” (FG2: 501-503)

Contact with many professionals appeared to have heightened Elspeth and her partner’s awareness of their unique understanding of their child and of the importance of this in relation to the expert knowledge of others.

Lorna and Maureen (FG3) also reflected on how they modified advice in the light of their knowledge of their own children:

Lorna - “I tend to find that everybody, everybody’s usually got an opinion on how to bring your children up, what to do; and all the rest of it, and I tend to find that I collate it all and I think ‘Now what would work’ you know, some suggest such and such and I then I have to go back and look at my child and I, you know, knowing her or him, but I tend to collate a lot of information and digest it and think, ‘Well, I’ll try that.’”

Maureen - “Well, I think because every child’s different, you’ve got to take the advice you’re given and say well ‘What’s right for mine?’ because, because something’s worked for someone else doesn’t mean it will work for yours.” (FG3: 684-695)

Thus Lorna and Maureen emphasised the importance of learning to treat their own children as individuals.

Jasmine (Int.2) summed up the sentiments of many parents:

RH - “Do you think there’s any help people can be given to be better parents or to learn parenting skills?”

Jasmine - “I think because it’s not - it’s not set in black and white you know every child’s different - so there’s not definite rules as such. Em, each child’s different and the parents are all different, it depends on how you want to do things, I suppose.” (Int.2: 388-393)

Jasmine suggested that it was the unique blend of the parents’ and children’s personalities which made each situation different.

5.18 Parents' approach to dealing with parenting problems

During the interviews and focus groups, parents often talked about problems encountered in the course of bringing up children. Learning parenting skills was said to involve becoming skilled at dealing with problems, either resolving the issues or learning to accept them as 'just a phase.'

To Sheila (FG2), the whole process of childrearing was synonymous with solving problems in a way which suits the individual child:

"But when you're a mother you're doing it yourself all the time. Being a parent is really dealing with situations all the time that you have to say 'He's crying, why is he crying.' You go through a whole list, and really you're thinking that way all the time, trying to work out things. And because it's your child, you sort of get tuned in to him in a way that you couldn't really with anyone else's and you know what generally works and I see other mothers maybe dealing with their children and I think 'I wouldn't do that,' but maybe I would if it was mine." (FG2: 416-424)

Sheila's comments suggest that parents gain confidence in their role by learning to resolve children's problems successfully, in the light of their unique understanding of their child.

Many parents said that they had to solve most childrearing problems themselves, because of the need to make sure that the approach was suitable for their child, whom only they really understood, although they considered advice from friends, family, professional and books in the process. Wendy (FG6) described how she learned to look at all the advice she was given, before deciding her own plan of action:

"Aye, and you talk to other mothers and you talk to your own family, but I think at the end of the day, you take a wee bit frae there, a wee bit frae there, and a wee bit frae there, and you'll make up your own mind." (FG6: 599-602)

Similarly, Lorna (FG3) reflected on how she critiqued advice in relation to how she thought it would suit her own child:

"You get so much advice on how to bring your children up, what to do; and all the rest of it, and I tend to find that I collate it

all and I think 'Now what would work,' you know, some suggest such and such and I then I have to go back and look at my child and I, you know, knowing her or him, but I tend to collate a lot of information and digest it and think, 'Well, I'll try that.'" (FG3: 689-694)

Wendy and Lorna appeared to be taking advice and modifying it to suit the individual children.

Some parents said that support from others played the most important role in helping them deal with problems, because when children were going through a difficult stage, their self-esteem was low, they were tired and they had negative feelings about their child. Elspeth (FG2) outlined the way in which she appreciated support from others while she dealt with child-related problems herself:

"It's actually more the support of friends. Friends will say, I think you're doing brilliantly. I don't think you could do any more, any better. It's people who can support you while you deal with the problem and people who help boost your self-esteem when you're at your lowest. They say look you're doing as well as could be expected in that situation. It's not so much the advice, at the end of the day you use your past experiences and do what you believe to be right, and deal with your children that way." (FG2: 308-315)

Isobel (FG1) described how support from others helped her to maintain her self-esteem and to feel more positive about her child:

"Cos when you're going through a difficult spell especially if he's not sleeping or having tantrums, you get so tired that you kind of lose the place a bit, it all gets a bit out of perspective, and you think it's something you've done, and everyone thinks you're pretty awful, and it's you that needs the help then. And sometimes you can really start to hate your child, well at least I did when he just started being defiant all the time, and even someone treating him like they think he's quite nice makes you feel better." (FG1: 299-306)

Both Isobel and Elspeth's comments suggest that social support was important to them in resolving childcare problems because of the importance of feeling self-confident and positive towards their child when they were going through a difficult period.

Many parents said that when they were looking for help with dealing with problems, they appreciated being given a chance to discuss their own views, which helped them to gain confidence in their own decisions. Joyce (Int.7) elaborated on this concept:

Joyce - "They (health visitors) say, 'do you have any thoughts on the matter?'"

RH - "Do you like that?"

Joyce - "And I'll say 'yes I do have a thought on the matter, what about such and such?' and .. Yes I do. It makes me think anyway. It's not just me taking from them, It's me thinking for myself. It's what I do in my classes, not telling people but getting them to work it out for themselves."

RH - "Right, so you think that's a better approach ..?"

Joyce - "Yes, you learn more that way, thinking for yourself. You see I mean I usually have thought about it anyway." (Int.7: 481-489)

Thus Joyce believed that her skills were enhanced by being encouraged to work out her own solutions to problems.

Parents said that they liked to be given options when they were seeking advice because it made them realise that there is no easy answer to most problems; this approach also suggests that often there is no guarantee that a strategy will work, and therefore failure to resolve a problem is not a reflection of the parents' ability. Eleanor (FG2) explained why she preferred to be given a variety of possible solutions:

"Yes, it's good to have a range of options, I think most of us in our heart of hearts would like someone to say 'Right, this is what you should do,' but then if it doesn't work you kind of feel more of a failure, whereas if you have different things, then you can try a few and you kind of realise there is no easy answer. Some children need a firm hand and to know who's in charge, whereas others are shy and need to be given a lot of encouragement. You try out this this and this, and usually it's the last thing on the list that works." (FG2: 410-418)

For Eleanor this approach lessened her chance of failure, and Eleanor appeared to recognise that failure would have detrimental effect on her self-esteem.

There were situations when parents did appreciate direct advice, usually when they had tried to resolve an issue themselves over a long period of time. Elspeth described a situation where she was going round in circles and having a “pantomime” with her child and needed some direct advice to resolve it:

“Well, I mean, I went to my health visitor with a toilet training problem and she retired shortly afterwards (laughter!) And I said I cannot solve this problem, and she said, ‘Look, if I was in your shoes, this is what I’d do. Take him out of nappies at night completely, and if you can put up with the mess for a few weeks you’ll solve the problem,’ and it was someone saying to me, the way my mother would, ‘look try this,’ and as it was I ended up in hospital having number 2 and my mother sorted it out, and it worked. But that’s the time when she said ‘look, try this, just try it, I don’t guarantee that it will work, but give it a shot’, and I thought ‘she’s right.’ I needed someone to say to me, ‘look, it’s time he went to the toilet,’ instead of all this pantomime, and it worked, and sometimes it’s just time to listen.” (FG2: 449-461)

Elspeth therefore found that direct advice was useful in helping her to take a more lapproach to her child’s toilet-training and to realise that she needed to take a firmer stance with her child than had previously been the case.

Parents said that what appeared at first to be a problem could be reappraised as a normal stage of development, as Lorna (FG3) described:

“I think you’re just looking for someone to say it’s OK. This is all right- it’s normal- it’s just something that happens.” (FG3: 659-660)

Reassurance could therefore help parents change their assessment of a situation from problematic to normal.

5.19 Summary and discussion

The findings of the present study as they relate to parents’ experience of their role suggest that parenthood is associated with an overwhelming sense of responsibility

to children and to society, with parents believing that their children's future success and happiness, as individuals and in relationships with others, depends on the upbringing they provide. The transition to parenthood was portrayed as especially problematic for many parents, often resulting in feelings of constant responsibility for and presence of children, changes in relationships between parents to accommodate the needs of family life and loss of self-identity. Thus participants' depiction of the transition to parenthood supports Le Master's (1957) assertion that the birth of a first child constitutes a 'crisis' for most parents, validating Erikson's (1950, 1959) broader theory that all new and difficult developmental tasks involve crisis and intrapsychic conflict. The early days appeared to be most challenging, with the transition being complicated by anxiety, fatigue and practical problems such as those associated with breast feeding. Parents with previous contact with children appeared to cope with both the transition to parenthood and with caring for children much better than those with little prior experience, for many of whom the demands and feelings associated with the role came as a "shock" (Int.17). While parents seemed to derive a sense of meaning and purpose from having children and enjoyed special occasions and memorable moments, day to day life with young children was commonly depicted as being mundane and tiresome, as portrayed also by Boulton (1983) (see Chap 2.5 p21). Parents' aspirations for their children appeared to be affected by their own life histories, wishing either the same or better for their children.

Parents' sense of responsibility to provide children with a good upbringing involved the perceived need to instil a sense of discipline in children both in providing them with a sense of order and morality and in maintaining some control over their children's behaviour. While parents generally believed that the physical punishment which most of them had received as children was acceptable at the time, they considered this approach to discipline to be no longer appropriate. However, many had little understanding of alternative ways of trying to modify children's behaviour.

As proposed by Aldous (1998), early involvement in childcare by fathers was shown to be important in order to foster good family dynamics. However this was often

hampered because of mothers' greater involvement with children in the early days due to breast-feeding, more time spent with children due to maternity leave or mothers not working full-time and, as highlighted by Ferri and Smith (1996), fathers working long hours. Participant mothers also spent more time during pregnancy preparing for their new role than did fathers. This underlines the need for professionals such as midwives and health visitors to be aware of the difference in the rates of transition between mothers and fathers, as noted by Cowan and Cowan (1988).

In relation to mothers and employment, many parents believed that both mothers and their children benefited from mothers working: mothers from the stimulation and sense of identity conferred by work, and children from the stimulation of being with other carers and children. Although the participants contained only four families with both parents working full-time, these parents gave the impression that this model of family life allows little opportunity for making and maintaining relationships with family and friends. Part-time work for mothers appears to allow families to combine traditional and contemporary aspects of family life, with the onus of responsibility for children remaining with the mother.

Social support was portrayed as being very important to parents both in coping with parenthood and also in learning about childcare; the transition to parenthood seemed to be frequently associated with an increased awareness of and need for social networks which can provide support for parents in their new capacity. There appeared to be increased contact with extended family and strengthened family bonds resulting in an increased sense of family identity for parents; parents who were isolated from their extended families appeared to feel that they and their children were missing an important part of family life. However, extended family was presented as a very limited source of practical help and useful advice in relation to childrearing. The role of extended family for many participants in the study mirrored Finch and Mason's (1993) proposal that for many contemporary parents, family support represents more a reassuring possibility than a daily reality, but helps parents to create a sense of identity as a family. For many parents, friends appeared to be the

main source of social support. The establishment of new social networks seemed to be vital for many parents in coping with the challenges of childrearing, although families without support from family and established friendships found that these new social contacts could not provide the sense of belonging which they lacked. The equal relationship which exists between friends at a similar stage of parenthood generated the mutual support and sharing of knowledge and ideas which facilitated parents' ability to cope with their role and gain knowledge about childcare issues. Social support from parents of older children was also an important means of learning about parenting issues by providing models which could be copied or avoided depending on the perceived outcomes of the strategies used.

Parents learned a considerable amount from their own experience of bringing up their children, both about caring for children and also about coping with the stresses inherent to the parenting role. This awareness of experiential knowledge resulted in an apparent caution on the part of parents about trying to give advice to others and also an increasing reluctance to accept prescriptive advice from others as their confidence grew.

Solving childrearing problems appears to be an inherent part of the parenting process, which increases parents' knowledge, confidence and coping abilities. Parents demonstrated an awareness of their unique understanding of their own child which was deemed by most parents to be a vital component of the successful solutions to childcare problems, and which was enhanced by problem-solving activities. Parents valued support from family and friends while they sought out their own solutions, but looked for expert advice in the early days, when both their understanding of their child and problem-solving skills were limited.

Although the demands of parenthood were often met by parents' own resources and those of their social networks, there appeared to be a perceived need for other sources of support and advice for many parents.

CHAPTER 6: PARENTS' PERCEPTIONS OF THE HEALTH VISITING SERVICE

6.1 Introduction

In the previous chapter parents' accounts of their experience of parenthood was explored. This provides a background to the present chapter which examines parents' perceptions of the health visiting service in the context of their experience of parenthood and in the light of other sources of support and advice available to them.

The chapter begins with a consideration of parents' understanding of the role of the health visitor. It then continues with an exploration of the parent-health visitor relationship and of the relevance for some parents of health visitors having personal experience of childrearing. The chapter ends by considering parents' perceptions of good and bad health visiting practice. Analysis of the data revealed that these different aspects of the health visiting service as portrayed by parents were interdependent: the way in which parents perceived the role of the health visitor, the relationship parents had with their health visitor, and the positive and negative aspects of the service from parents' perspectives each impinged on the other facets of the analysis.

6.2 The role of the health visitor in surveillance and support

The health visitor was generally believed to have responsibility for both policing and supporting families.

Some parents believed that health visitors were obliged to make checks on children to ensure that they were being well cared for, and were "paid to be nosey" (FG6: 644); in some cases parents considered this to be an important aspect of the health visitor's role and were critical when they had not had contact with their health visitor for some time.

Janette (FG5) emphasised the need for health visitors to visit families at home:

"You've got to come to the house to see it and I mean you can get your bairn a' nice and dressed and go the health clinic and

that bairn's perfect. How do they ken that bairn's perfect in the hoose?" (FG5: 661-664)

Janette seemed to believe that both the child and the home environment had to be checked in order to monitor children's welfare.

Neil (FG5) believed that health visitors have a professional duty to check up on children:

"I think health visitors have got their ain sort of - if they dinnae dae it and something happens to a bairn, yous are going to be caught out, so there has to be something that where they say, 'Well I need to go in whether or not I think you're looking after yer bairn. I maybe need to visit you at least once a year to see.'" (FG5: 738-742)

Neil appeared to be under the impression that health visitors could face disciplinary action if one of the children on their caseload was found to have been abused or neglected, and the health visitor had not had recent contact with the family.

Wendy (FG6) explained how she was surprised that no attempt was made to follow up her child's welfare when she defaulted appointments for routine developmental checks, especially when she had just registered with a new doctor's practice after moving house:

"I mean I took Holly up for her 36 month check or whatever it is, once she was really late, and I was a wee bit worried because I would think the doctor would write something on paper, and a new surgery and all, and they hadn't seen Holly, and three times they wrote for her 36 month check and I didn't think it was followed up enough. What if I was, you know thumping Holly, for no reason, things like that. Now, I was a bit surprised at how slow they were at the surgery. Eventually I took her up and great, and then they just tell you everything's all right." (FG6: 712-720)

Wendy, Janette and Neil's comments imply that they believed that health visitors should monitor all children for signs of abuse and neglect, even when there is no reason to believe that children are at risk.

In contrast, Joyce (Int.7) saw the role of the health visitor as being to check that the parents were coping:

“Somebody coming in specifically to check that you were coping all right, yes it was good aye, definitely. It did make you feel that you were getting care yourself, and that, you know, the birth was not the end of the story, because he was such a big shock compared to what I expected. I just thought it would all come naturally, you know, being a mother.” (Int.7: 557-562)

Joyce appreciated the pro-active approach of the health visiting service, which she saw as a continuation of the care she had received from the midwives during pregnancy and immediately after the birth.

6.3 The role of the health visitor in dealing with medical and developmental problems

Parents said that they approached their health visitor about medical problems which were “something wee, like I think I’m wasting a doctor’s time” (PPIMC: 328-329).

Barbara (Int.3) approached the health visitor when her child was unwell enough to cause her anxiety, but she felt that he was not sufficiently ill to warrant seeing the doctor:

“Aye, we’ve phoned her before even when he’s not been perfectly well and I’ve not been sure what to do because we knew he wasn’t that bad, if we wouldn’t have gone to the doctor, I’ve used her as a sort of stepping stone in between.” (Int.3: 656-659)

Sometimes parents were looking for advice about caring for children with minor ailments, at other times were seeking reassurance from the health visitor that it was safe not to consult the doctor or confirmation that they did need to consult the doctor and were not being over-anxious.

The health visitor was sometimes also seen as being more accessible than the doctor. Parents looked for advice about the management rather than treatment of minor illnesses from the health visitor. Barbara (Int.3) described her appreciation of her health visitor with dealing with her baby’s minor symptoms:

“Often, I’ll like get ideas on what to do. I mean the first time he was unwell was at Christmas and he had a cracker of a cold, he couldn’t breathe and I’m trying to think, I mean if I get a cold I

know it will go away again tomorrow, so we're like what do we do, but a silly thing like putting a pillow under the mattress to raise his head, you know, okay, I never thought of that, didn't know about that. So it's little things like that that are a good help. If you'd gone to the doctor depending on who you saw, you'd be fobbed off." (Int.3: 674-682)

Barbara appeared to believe that the health visitor acknowledged her concern about her child's illness and suggested simple measures to alleviate the symptoms, whereas the doctor would be dismissive of her once any significant medical problem had been excluded.

Parents also asked the health visitor about general health concerns, for example, where there was a family history of asthma or eczema and the parents wanted to know about ways of minimising the risks of their child developing the problem.

However, some parents were unsure about the boundaries of the health visitors' expertise. Susan (Int.5) was disappointed with her consultation with the health visitor about a small lump in her child's neck, which she considered a trivial matter. The health visitor had referred her to the doctor and as a result Susan decided that the health visitor was not able to deal with medical problems as she described:

"Yes, I feel, it's like at the clinic, I get the impression that if you go with a medical problem you'll just be sent to see the doctor anyway, so I'd probably just go straight to the doctor." (Int.5: 430-432)

Susan was obviously unaware of the possible sinister causes of her child's apparently trivial symptom of which the health visitor would be aware but would not have the expertise to exclude, and so she formed the opinion that health visitors are not able to deal with what she perceives as a minor ailment.

Analysis of the data suggests that the health visitor was seen by many parents as a source of practical advice and reassurance but that there could sometimes be some ambiguity about the extent of her role in dealing with children's health problems.

6.4 The role of the health visitor with families identified as requiring additional support

Parents with or without extended family saw the health visitor as being a source of support to parents who do not have their extended families for help and advice.

Carol (Int.11) described how she had received considerable support from her health visitor which she greatly appreciated because her family were down south. In contrast, she attributed her sister's minimal contact with the health visiting service to her easy access to family support, as discussed in Chapter 5.11 p150.

Joyce (Int.7) also linked her need for and appreciation of health visiting interventions to her lack of family support:

“I think they (health visitors) should be there for parents who need it (the health visiting service). Like I said, I don't have this family backup and sometimes I think ‘why is he being like this?’” (Int.7: 442-445)

In contrast, Susan (Int.5) considered the role of the health visitor as being confined to her child's routine developmental monitoring because her sister, who had a child just three months older than Susan's and with whom she had frequent contact, provided all the advice and support she required. Joyce, Carol and Susan all saw, from different perspectives, the health visitor as taking the place of absent family.

Many parents thought that health visitors, as well as concentrating on isolated families, also focused on other vulnerable parents such as young mothers and lone parents. Arlene (FG5) was typical in her understanding of the importance of the health visiting service in supporting single parents:

“And I used to feel sorry for this wee lassie because she was on her own and you could see she was toiling eh! And I says ye ken - that's a shame, and it's a good job that's there's health visitors.” (FG6: 759-761)

Lorraine (FG5) reckoned that the support she had received from her own health visitor was due to being only sixteen years old when she had her first child:

“...and at that time I had a good health visitor that I mean she was a lot of help at that time, because I was so young, I think she kind of took me under her wing.” (FG5: 202-204)

Elaine (Int.4) described how her friend was having support from her health visitor because one of her children had behaviour difficulties, and perceived the help as being targeted at the mother and this particular child:

“Yes, I think a lot of people do need help from their health visitor but I don’t think I didn’t need guidance. I mean some people need a lot of help with their children and I mean my friend at work - her middle child they’ve got some - I don’t know what it is - but he’s got a lot of behaviour problems and her health visitor visits her and she helps her quite a lot, but I think the other children - she doesn’t need help with them very much. I think it depends on the child and on the situation and how much professional help you really need.” (Int.4: 249-257)

It appeared that Arlene, Lorraine and Elaine understood the health visitor’s role in terms of offering support on the basis of assessment of need rather than routinely. While for Arlene and Lorraine, the perceived need for support was based on the mother’s vulnerability, Elaine believed her friend’s need for increased health visiting support was due to the problems relating to the child.

Elaine had previously expressed some surprise that another friend had needed more support than that provided by her mother because, unlike Elaine, she lacked confidence:

“I’ve got a friend who had a baby about a year ago, and she wasn’t very confident at all and like she had her mum there and all, and yet she still needed more reassurance from the health visitor...but I think I’m already quite confident within myself.” (Int.4: 181-186)

Elaine went on to explain how her previous childcare experience minimised her need for help from the health visitor in relation to childcare.

“As well, my mum’s the oldest. She’s got sisters, and they’ve all got children and stuff and I grew up with family all around and I was never really like “God, what do I do?” (Int.4: 186-188)

“I mean my younger sister she’s eighteen and she’s got a baby and I think she’ll be all right, I mean she’s looked after Chloe, so she’s got an idea of what it’s about...I mean for an only child, that’s grown up by yourself, and you don’t really know much about children then it’s probably really quite a good thing but I think it really just depends on the person and what their background is.” (Int.4: 277-283)

Like other parents, Elaine saw the health visitor’s role as providing support to families in difficult circumstances and was surprised that her friend needed the health visitor as well as her mother in order to cope with what Elaine judged to be ‘normal’ parenting.

6.5 Parents’ understanding of the focus of health visitors’ work

Some parents saw the health visitor as being concerned mainly with babies. Wendy (FG6) described how she felt that “they drop you later on,” (FG6: 711) when she felt she needed help, which she sought from the nursery school staff.

Jill (FG4) explained how she saw the health visitors’ role:

“I think of the health visitor as the woman who deals with the new mother and the new baby and then when they get to that stage where they finish going to the mother and baby clinic that’s it.” FG4: 622-624)

Jill associated the health visitor only with babies and new mothers, and not with families beyond this stage.

Elaine (Int.4) had thought that the health visitor’s role was with adults as well as children, but found her health visitor was concerned only with her child. Elaine explained why she believed that health visitors should be more involved more with parents than she thought they were:

“But I read somewhere that the health visiting service is to do with adults as well, and this was all to do with Chloe. I don’t really think it should be about child development because the children are going to develop regardless and it should be about how parents develop. I think it has to be a bit more about parents’ feelings.” (Int.4: 324-329)

Elaine went on to describe a period when she was very stressed and knew that this was a situation where the health visitor should be involved; however, because she felt that her own health visitor was focused only on her child, she did not approach her:

“ A few months ago when I was doing exams and we had just split up and I was quite - no suicidal or anything - but I was seriously stressed out and I knew I should go to my health visitor, but I just kind of got over it myself.” (Int.4: 336-339)

There was a conflict between Elaine’s understanding of the role of the health visiting service in general and the way in which her own health visitor had portrayed her role to Elaine, the latter being more influential in how she reacted to her stressful situation.

Isobel (FG1) did not really know what the role of the health visitor was, but thought that it was focused on the physical health of children, not with behavioural problems, such as sleepless babies:

“ I think the problem with health visitors is that well, I was never really sure what their job really was. I thought of health visitors as being only interested in health, as in physical health, and that if children were basically well, they weren’t really interested. If they were eating and healthy they wouldn’t really want to know and things like sleepless babies they wouldn’t want to know. If they were well and developing normally, then anything else won’t be the health visitor’s job.” (FG1: 268-275)

Isobel seemed to believe that health visitors are concerned only with children’s physical health, and have no role in parents’ welfare and children’s behaviour problems.

Rosemary also thought that health visitors are concerned only with children’s medical problems and post-natal depression:

Rosemary - “I know there was an offer from <HV> to phone up any time but I wasn’t really sure what her role was.”

RH - “So would you?”

Rosemary - “Well, I thought she was medically orientated and I didn’t see it as about myself in any way. If I was feeling dreadful because my mother had a nervous breakdown with

post-natal depression so I was well aware about that and I would have contacted her about that but I wouldn't have gone about sleepless nights or whinging or any behavioural child things. It would never have occurred to me.” (FG4: 626-635)

It may be that Rosemary saw a role for the health visitor in the management of post-natal depression because of its direct relationship with childbirth or because she saw it as a medical problem. Although Rosemary's health visitor had asked her to get in touch if she required help, Rosemary was unsure about the circumstances when this would be appropriate. This demonstrates the need for health visitors to discuss their role, particularly with parents who have little contact with the service in the early days.

A few parents believed that their health visitor might have a role even after their child was at school. Linda (Int.6) said that she would consult her health visitor even when Robbie was at school, because she was attached to her GP surgery and was therefore part of the primary health care team.

Tracey (Int.10) thought that she would approach her health visitor in the future because the health visitor had already explained that her role included dealing with older children:

“Because getting back to <HV> she's already says if I've ever got any problems, she's always ma health visitor, just to get in touch. So ah think say ah did have a problem wi' Gordon (child) when he was about maybe 9 year old I think I would still maybe go back to her.” (Int.10: 1036-1040)

Tracey's health visitor had made it clear that she would always be available for Tracey.

Parents therefore demonstrated a range of perceptions of the breadth of the role of the health visitor, based partly on their own and others' experience and also on a more general understanding.

Some parents who had initially considered the health visitor's role to be very narrow, had become aware of more diverse areas of the health visitor's work. Carol (Int.14) was surprised when her general practitioner referred her to the health visitor in

relation to the management of pre-menstrual syndrome, having previously thought that the health visitor was concerned with mothers only in relation to post-natal depression, mastitis and other conditions directly related to childbearing.

Rosemary's (FG4) perception of the health visitor's role was changed by the experience of a friend whose health visitor was very involved in supporting her through marital problems:

Rosemary - "I find it very interesting. I have a friend in Dundee, she used to live here, right here, and she moved to Dundee last year and we both had our children together and I saw the health visitor a couple of times and that was that - I didn't really feel I needed anybody - so did she - and she went to Dundee and the health visitor seems to have got very involved from the very beginning - she's got a second child but she's now having terrible marital problems to the extent that her husband's moved out for a while and the health visitor from what I can tell - from what she's saying to me - is playing a key role in helping her get through this. It started off initially about the effects it was having on Craig who's the same age as Craig who's just gone completely - of course you don't know if he would have been like this anyway - or if it's with everything that's going on but the number of times she mentions that the health visitor said this and initially I noticed it was all about Mark but then it actually widened as well as things got really quite bad so this person - and it would never have occurred to me, I must say - is obviously really supporting the family."

RH - "Does that surprise you?"

Rosemary - "I was gobsmacked." (FG4: 599- 620)

Rosemary's description of her friend's experience of the health visiting service was in contrast to her earlier comments that she did not really know when it was appropriate to contact the health visitor, but had assumed her role to be very narrow.

Some parents admitted that they were unsure about the role of the health visitor and felt that the health visitor should be more explicit about her remit. Often parents only found out about the wide range of interventions provided by the health visiting service because health visitors offered input relating to situations that parents had not previously associated with their role. Analysis of the data

therefore revealed that parents' perceptions of the role of the health visitor were diverse, and could be widened or narrowed by direct and indirect experience of the service, or could remain unclear.

6.6 The role of the health visitor in addressing problems which cannot be resolved by family and friends

Parents often mentioned the role of the health visitor in helping to resolve problems which did not respond to lay advice or which had not been encountered by family and friends.

For example, one mother who was breastfeeding, in contrast to other members of her large extended family, could get advice about most other concerns but relied on her health visitor for help and encouragement with this aspect of child care because she was determined to succeed, and realised that her family were both lacking in knowledge and were perhaps trying to persuade her to give up.

Elaine (Int.14) said that she usually asked her mother for advice but "if it's a big problem" (Int.14: 105) she approached her health visitor for advice.

Sharon (Int.1) described the hierarchy of sources of advice which she used when she had a childcare problem:

RH - "What about when you have any sort of wee problem with him, who do you tend to go to for advice, say he was wasn't sleeping or, not real illness..?"

Sharon - "We work it out together. Me and Johny work it out together. And then if it's something that we just can't like figure out what it is, I'll probably end up phoning my ma or my sister, one of the two."

RH - "Are they quite good, do they give you good advice?"

Sharon - "Oh aye. It'll be like 'Do this and if that doesn't work, do this and if that doesn't work phone the doctor' sort of thing, if he's ill.' or if it's something like feeding or he's not ill enough for the doctor I get in touch with <HV>" (Int.1: 306-317)

The health visitor was therefore seen as complementary to family and friends for help in childcare issues, when the child was not deemed as requiring medical advice. There appeared to be a fairly complex sequence of judgements involved in the decision making process when parents were looking for help with childcare problems.

6.7 The health visitor as a resource for information

Parents commented that they found the health visitor to be a useful resource for information about facilities such as toddler groups, childminders and swimming lessons, as they assumed health visitors to have a good knowledge of local facilities because of their contact with other families.

6.8 The role of the health visitor in providing reassurance to parents

Many parents saw the role of the health visitor as being for reassurance about their parenting skills, as well as about the health and development of their child.

Avril (Int.17) described the role of the health visitor as provider of reassurance on three occasions during the interview with her:

“I just liked the fact that I knew that if I thought there was anything wrong or that I could just go (to clinic) anyway.”
(Int.17: 256-257)

“Aye, by reassuring me that I’m - that what I was doing was OK and just being there and being able to go and say ‘Well, what do you think about this?’ and being able to give an answer.”
(Int.17: 374-376)

“I like going up (to the clinic), but I didn’t just always go because I wanted something. I used to take her up regularly to get weighed every week and while I was there if I did have any problems I could discuss them.” (Int.17: 554-556)

Avril’s explanations for attending the clinic make it clear that she was seeking reassurance, especially about her performance as a mother rather than just about the health and development of her child. This reassurance from a professional source may reinforce that provided by parents’ social networks.

Dawn (Int.8) described how she used the clinic:

“It was a mixture of both. I went every now and again and if I had something that I wanted to ask I made time to go down and ask or I phoned her.” (Int.8: 388-390)

Dawn’s comment implies that going to the clinic “now and again” was associated with seeking reassurance while going with a specific reason was related to seeking information.

Linda (Int.6) outlined a specific instance when she had sought reassurance from her health visitor:

“I mean, they’re always there for advice and they always said, ‘phone if there’s anything you’re not sure about,’ and one day I did phone because I thought.. he sort of had a funny wee shiver and fell asleep and I thought he had a wee sort of fit or something like that and I phoned and Jan was on the phone and she said ‘check this and check that.’ I mean you never felt daft or silly for phoning them up with a question because they would always help and reassure you. I’d say they are very, very good that way.” (Int.6: 381-388)

Linda was worried about her baby but recognised that the incident was probably of little significance; the health visitor’s recognition of her anxiety was important to Linda’s understanding of the health visitor’ role with parents.

The health visitor’s role in providing reassurance to parents might be predictable in view of many parents’ lack of social support and experience of caring for children which has already been discussed.

6.9 The parent-health visitor relationship

Analysis of the data revealed that the relationship between parents and their health visitor is a major influence on parents’ understanding of her role and on the way in which health visiting interventions are conducted.

Many parents described their health visitor as being ‘like a friend,’ although they also acknowledged that they were not friends in the true sense because the relationship

was not reciprocal and because of parents' perceptions of the health visitor having a policing as well as a supporting role in families.

Building up the relationship

Parents who had a good relationship with their health visitor talked about home visits in relation to the development of the relationship. Parents who had had fairly intensive contact with their health visitor because of problems experienced by themselves and their children believed that the frequent home visits had provided an opportunity for parents and health visitors to get to know one another. Sharon (Int.1) described how being visited at home by her own health visitor's colleague had resulted in Sharon being less concerned about seeing her own health visitor at the clinic:

"I liked to see <HV> at the clinic, because I like to know who's dealing with my bairn sort of thing... but <HV> was on holiday so <colleague> came to see me at my mum's house so I got to know her as well, so now I dinnae mind who I see 'cos I ken them both...Because I'm a very inward person. I like to keep myself to myself. Although once I get to ken a person that's fine." (Int.1: 432- 452, 597-599)

For Sharon, a home visit from her own health visitor's colleague facilitated the development of a relationship which made Sharon feel happy to discuss concerns with her at the clinic.

Contact with the health visitor during pregnancy helped to dispel the negative image of health visitors held by many parents, as Barbara described:

"Because we met her beforehand, we got to meet her when we knew what to expect sort of thing. We'd been told, 'Oh, your Health Visitor will be an old dragon, kind of thing.' ...But when I met <HV> she was nice and I got on fine with her." (Int.3: 460-465)

The importance to mothers of meeting their health visitor ante-natally may be partly explained by mothers' reports of loss of identity and overwhelming tiredness in the early days after the birth, when they were less likely to feel able to form relationships with health professionals than before the birth of their child.

Parents described characteristics of their health visitors which justified depicting them as being like friends. These often involved health visitors going beyond what parents saw as their official duties and making parents feel valued as people rather than as clients.

Janette's relationship with her health visitor was enhanced by her once doing some basic shopping when Janette's child was unwell; Janette considered this to be outwith the health visitor's official remit and therefore associated with a friendship relationship.

Tracey (Int.10) described how her health visitor went beyond what Tracey considered to be the official remit of her role:

"I remember the first year, the first Christmas we had in here ay. We went up to the shop and we got a wee boxi chocolates for her frae Gordon and she was over the moon. You know she was. It was just like to me she was like a friend sort of thing and she would come and she would visit and that and the bairn used to jump up on her knee and would sit and get a cuddle or whatever. Even now I've seen the bairn. He'll maybe go up to <HV> in the doctor's surgery and get a kiss and a cuddle off her you know. Ah dinnae think a lot o' other health visitors basically I dinnae think some of them would have the time o' day. You know they wid dae their job and that would be it. But whenever <HV> sees you in the surgery or oot in the street or something like that she always stops. She always seems to be in a rush though you know. And she would always stop and talk to you or that. Like even half the time she'd come up here and you'd have a cuppa tea and a biscuit or something and she'd say, 'Oh I've not got much time.' And then you'd find she'd sit here for about an hour to an hour and a half. You know you'd just sitting away blethering. She still hasnae done any of the work that she was supposed to have done and she's already been here about an hour or so, you know, just sitting having a conversation."
(Int.10: 668-689)

Tracey's quote provides a good insight into the reasons why she considered her relationship with her health visitor to be one of friendship: showing affection to her child, recognising Tracey and her child in informal meetings, making social conversation and having tea rather than progressing with what Tracey believed to be the 'official business' of health visiting, and making time for Tracey when she

appeared to be busy. Tracey's recollection of buying her health visitor a present at Christmas reinforces the image of friendship. Tracey's partner Jim later described the health visitor's approach to her work as "more than just a job to her" (Int.10: 710). However, while Tracey seemed to believe that the role of health visitors was to monitor children's welfare and development, and that the time spent talking could be categorised as 'unofficial' business, this may have provided an important arena for the health visitor to work with the family to bring about changes that could have positive influences on the child's health and development, especially in view of the history of violence within the father's family and his own attitude to discipline (see Chapter 5.7 p138)

Deirdre (Int.18) explained how she felt that her health visitor did not like to divulge personal information about herself but Deirdre felt that she needed to know something about her health visitor:

"I think she's a person who felt that she shouldn't talk about herself, and I was awfully keen to know, because of the person I am ...have you got children? What do they do and everything? And eventually I did find out a little bit about her. I just quite like to know about her as a person. Because of the role she had she wasn't like a kind of em I was going to say a doctor. But I've actually found the doctors are very kind of easy to relate to. Em you know because she was almost like a friend coming."
(Int.18; 752-759)

Deirdre revealed her expectation that health professionals would be difficult to relate to and appeared surprised that these images were not borne out in reality. She was also very touched when both her doctor and health visitor wrote personal letters to her when she had a miscarriage, which made her feel that they had genuine concern for her as a person; it therefore seems reasonable that this approach might result in clients wanting to know something of professionals' personal backgrounds in order to create a more reciprocal relationship.

Health visitors who were considered by parents to be going beyond their official duties were seen as friends, and parents felt they had a closer relationship with them than with those who seemed only to do what was required. In some cases the relationship to some extent resembled friendship because the health visitor divulged

some personal information which made parents see them as individuals rather than as purely in their professional role.

Susan (Int.5) who described herself as very shy and reserved, and had a sister nearby for support and advice, felt that she had not got to know her health visitor very well because she did not really see a role for health visiting in her circumstances.

Elaine (Int.4) felt that she had never built up a good relationship with her HV.

“One thing - I think as well, <name> my health visitor, she was a really nice person and everything but I don't know there was something - I didn't really relate to her very well. There was something. It's not that - I couldn't talk to her about anything to do with me, my personal life, I couldn't like she wasnae well you know like - either she was talking or I was talking, we were never really talking together.” (Int.4: 316-322)

Elaine went through a bad patch and would have gone to her HV if she had felt more at ease with her.

RH - “Would you have gone to a health visitor?”

Elaine - “Yes, if she had been more, not necessarily younger, but I don't know - if she was more open and if during the time she was visiting, if we had actually spoke to each other, but it was like ‘I'll give you these details and you give me those details’ - that's what it was like - you know and if there was more of a rapport in it, I think when I went through that patch - I don't know.” (PPI JG: 314-320)

Elaine's description of the lack of rapport between her health visitor and herself illustrates the importance of the relationship between health visitors and parents in facilitating successful health visiting interventions and in ‘gaining access’ to clients (Luker and Chalmers 1990) and uncovering needs (Collinson and Cowley 1998).

Some parents who had established a good relationship with their health visitor found it difficult to adjust to a change of health visitor. Deirdre (Int.18) reflected on her reluctance to approach her new health visitor when she was depressed:

“If <first HV> had been still here she might have picked up on my getting depressed sooner than when I actually went with it to the doctor. ‘Cause my husband said I think you've really got to go to the doctor. I think I would have been going. I probably

would have gone to see <first HV>. I would have thought, 'well I'll just go and see <first HV> and have a chat,' whereas I didn't. You know I had a new health visitor and didn't know very well and just didn't feel that I could do that." (Int.18: 892-899)

Although Deirdre's understanding of the health visitor's role was unchanged, she felt unable to approach her new health visitor because she had not established a relationship with her.

6.10 Parents' understanding of the contribution of health visitors' personal experience of parenting to their professional practice

When talking about the health visiting service, many parents expressed views about how they perceived the influence of health professionals' personal experience on their professional role with parents. Personal experience was seen by some parents to provide knowledge which could not be learned in other ways but more importantly, gave parents a sense of being understood.

Tracey (Int.10) believed that personal experience was imperative for professionals involved in advising parents on childcare:

"But to me if yi get somebody eh that's no got nae kids and then they're trying to tell you how to dae something, ah think that would be the harder part because, me ah just wouldnae listen. I'd say well what di you ken, you've not got any bairns. Basically cause that's ma attitude, you know. It's maybe a bit naive like, but that's the attitude I've got. Somebody wi' kids cannae tell. Somebody without children cannae tell somebody wi' kids how to bring their kids up because they dinnae ken how it feels theirsels'." (Int.10: 755-762)

Tracey believed that for her, health visitors without personal experience of parenting would have no credibility.

Maggie (FG3) described how she believed that all health visitors have the knowledge but those with their own children have a better understanding of parenting:

"You see I think they see it totally differently when they've got the experience - it's still the same pot of knowledge in many

ways but they really appreciate how different it is when you have this child 24 hours a day.” (PFGHG1: 1081-1084)

Jackie (FG3) provided an concrete example of a typical situation which she believed any parent would have had:

“But I feel they haven’t had the experience of being in Safeways aisle at three o’clock in the afternoon with a screaming toddler.” (FG3: 1032-1033)

Many parents associated health visitors having personal experience of childrearing with the ability to empathise with parents and their situations, as Rosemary (FG4) explained:

“But even if their theories don’t work, still the fact that they’ve been there everybody’s, everybody’s children have done it. They empathise with how you feel, say you’re really tired or you know you’re confidence is gone that’s what makes the difference, they understand the element of the child and how wilful they can be, and how much they can just decide not to go to sleep.” (FG4: 702-707)

Maureen and Lorna (FG3) also explained the importance of personal experience in making health visitors empathic:

Maureen - “They have more of an empathy with you - you know. Their child maybe hasn’t had the major tantrums, but they’re bound to have had some.”

Lorna - “But if you were to say ‘I know exactly how you’re feeling because mine did such and such,’ then there’s a warmth between you I think.” (FG3: 1049-1054)

Many parents therefore appeared to believe that health visitors with children of their own were bound to have both a more comprehensive fund of ‘tried and tested’ solutions to childcare problems and a greater ability to empathise with parents when they were experiencing difficulties.

Parents’ reflections on how their own attitudes to children and their management had changed since becoming parents reinforced some parents’ belief that health visitors’ personal experience enhances their understanding of parents’ situations. Rosemary (FG4) explained how her understanding of childcare strategies had changed :

“But it’s all the stuff that we’re talking about here. Like I’ve got Craig who’s very different from Mark, who’s very different from Alice, who’s very- I mean before I had Craig I really did think that there was a book which had all the answers so I can’t see - I mean if they haven’t had children a lot of them will think like that so that approach I don’t know if that person had children but eh, if they’ve been told that certain things work they don’t realise that they don’t always work, and it’s not your fault...I mean, I think there’s something huge and incomprehensible about having a child which I couldn’t believe psychologically...I feel it’s something you can’t get out of a textbook.” (FG4: 690-697, 837-842)

Rosemary implied that she believed health visitors who did not have children would expect that textbook solutions to children’s problems would work if carried out properly, as she had done previously.

Maggie (FG3) likewise described how having children changed her perception of parenthood:

“It’s so much easier for them because you know yourself how it’s totally different going through it.” (FG3: 1020-1021)

Maggie’s comment suggested that she did not believe that health visitors’ training and experience might raise their awareness of aspects of parenthood about which she had learned by having her own child.

Some parents who themselves worked professionally with families reflected on their own awareness of how their experience as parents affected their own understanding and approach to parents.

Deirdre (Int.18) who worked with families of pre-school children with special needs contemplated how she felt that she would be better at her job now that she had a child of her own:

“But em now looking back I sort of think well it would help having my own children. I wouldn’t say that it was you know a criteria that you shouldn’t take on these roles with children if you haven’t had children. I think that em it’s a case of if I was doing that same job now I could bring more to the job by having had a child myself. I think certain things like I’ve not always been sensitive to, just out of not understanding when’s a good

time to plan visits. I mean you know parents will sort of say they have a sleep here but sometimes it's really difficult for me then to sort of push a little bit saying could I come at that time. Now I'd probably think well you know how would I feel or whatever. So yes there's. I could bring more to the job as a result of being a parent I think. Em I think I can understand the emotional side of being a parent a lot more having been one. So maybe if I go back to the work and it's through that field of pre school I'll perhaps be able to do a better job hopefully." (TPIMM: 788-803)

Deirdre would now go to greater lengths to arrange visits to families to suit children's routines.

Lorna, who had worked with emotionally disturbed children prior to having her own, reflected on how her approach to the parents of emotionally disturbed children would now be different:

"I mean I've worked with emotionally disturbed children and I mean I sat there saying to parents, ' Well, if he does that you do this and you're like - I must have sounded so condescending and patronising. Because I had my own and thought 'oh god what have I been saying.' But because I had the knowledge and they didn't and they were desperate they stood there and took it... Just letting the parents know they weren't getting it wrong. It was just I would appreciate more what a hard job they were doing. You know that their children are letting them down and embarrassing them, but just wanting their children better again. You know, I'm standing there in a condescending way, really the last thing they ever needed. " (FG4: 1086-1113)

Lorna acknowledged that while her knowledge had not increased, she would now have a more sympathetic and understanding attitude to parents, which echoes Maggie's previous comment her belief that health visitors benefit from adding experience to the "same pot of knowledge."

Iris (FG1), who was a pharmacist, recalled that before she had her own children, she relied on the assistants who were mothers rather than on her professional knowledge to advise customers on creams for nappy rash creams, "because they had a dashed sight more experience than me and they knew what worked and really they knew a lot more than me, even though I was the pharmacist" (FG1: 105-108). Iris

acknowledged her belief that personal knowledge could sometimes be more important than professional training, and suggested that she believed that this was probably the case for health visitors.

Maggie's (FG3) belief that personal experience of children is important was substantiated by the fact that two friends who were health visitors themselves approached her for advice about caring for their own children, and by their misgivings about their health visiting practice in the past. She recalled:

"I've got two friends who are both health visitors and both of them were health visitors before they had children and had children and then gone back to health visiting and both have said "Oh my goodness all this advice I gave out and what a load of rubbish it was". You know I pushed them and pushed them to breast feed and that's what happened to me and it was absolute agony, you know, and the funny thing was they were coming to me for advice after they had been giving advice. I was a mother and I had done it. You see I think they see it totally differently now because they've got the experience but a lot of it's still the same pot of knowledge in many ways but they really appreciate how different it is when you have this child 24 hours a day." (FG3: 1072-1083)

This admission reinforced Maggie's lack of confidence in professional knowledge alone, and does in fact suggest that health visiting practice can be enhanced by personal experience of childrearing.

Elaine (Int.4) understood health visitors to be professionally trained, like other health care workers, but thought that others in the area where she lived considered that the health visitor's expertise came from personal experience, and therefore gave little credence to health visitors who did not have children of their own:

"I don't see health visitors - I think a lot of people see health visitors like someone within their family giving them advice about their children that they're saying like your mum says oh put her nappy on like in a kite-shaped - the old-fashioned way - instead of this way and that way - stuff like that. But I recognise em - health visitors as a professional body, someone who is doing a job and they're like part of the health service and stuff like that. A lot of people see them like they should just be like your granny and have 20 kids and know from experience what they're talking about - no from education. I think that's

mostly the problem in areas like this - people who are no really educated themselves - they think what does she know because she's been to college or university you know - they don't really recognise it as you know - part of being a nurse - they think it's just an old busy body coming around, poking their nose in everything. (Int.4: 413-427)

Elaine (Int.4) saw the health visitor as a professional with specific training; however, she believed that other parents considered personal experience to be the most important criteria for being able to advise parents on childcare issues, and that these parents thought that health visitors' professional training gave them a unfounded sense of knowledge and power.

6.11 Parents' perceptions of good and bad health visiting practice

The findings relating to parents' perceptions of the role of the health visitor, the health visitor-client relationship and parents' views on how health visitors' personal experience influenced their practice have already been explored. Parents' perceptions of good and bad health visiting practice depend on these factors and are now considered within the context of these findings, and examples of good and bad health visiting, from the perspectives of parents, explored.

Good health visiting

Good health visitors were described as being easy to approach and understanding parents' perspectives and situations. Being "very human" (PPI CD: 70) and "really easy to talk to" (Int.8: 487) were considered to be important features of good health visitors, and parents said that they "could talk about anything" (Int.8: 487) and "could just pick up the phone" (Int.2: 478) to good health visitors.

Parents said that they appreciated when health visitors took their concerns seriously and recognised their anxieties about problems such as rashes and minor infections which parents recognised as probably being fairly trivial, but which are nevertheless worrying for parents.

Sheila (FG2), who had suffered from post-natal depression and was worried about people's views about herself as a mother, described her positive experience of the health visiting service:

Sheila - "My health visitor's fantastic. When I had my second one, I got post-natal depression and I didn't know what was wrong. One day I just sat and cried and I phoned the health visitor and she came rushing round to me, and she's been an absolute tower of strength to me. I mean she's been really fantastic, and every time she was passing and saw the car in the drive, because I don't go anywhere without the car, she'd stop. It made her late for everything. But she would stop, make sure I was OK and everything. She was fantastic, she was really really good. She organised day care. She did everything, and yet she didn't take over. She seemed to know how to handle me."

RH - "Can you kind of describe what was good about her, because it's useful if people can somehow analyse what makes a good health visitor."

Sheila - "She was capable."

RH - "And did you appreciate the fact that she came and saw you at home without you asking?"

Sheila - "Yes, it was really nice. It made me feel she really cared about me, and I think at the time, the way I was feeling, that was important."

RH - "You didn't feel that she was intruding or sort of checking up on you?"

Sheila - "No, well, lots of friends pop in, I'm always glad to see people."

Elsbeth - "And she probably sussed you out and worked out what suited you. A good health visitor can probably make that judgement, and she thought 'Sheila won't mind if I just pop in and see her, whereas someone else might not.'"

Sheila - "No, I really liked it. It really cheered me up that she took the time to pop up, even just to say 'How are you doing today?' Because I mean I was suicidally depressed."

RH - "Were you on medication?"

Sheila - "Yes. I was on medication and seeing a psychiatrist and everything, children in social work day care - childminders, she was really good and I mean she did all she could for me, and organised the child care right away, and so on and so forth. She was brilliant, I really felt she was on my side, against all odds, because I was rather scared and I thought they might say 'Right, we'll take your kids away from you.'" (FG2: 321-360)

Sheila believed that her health visitor gave her the practical and emotional support she needed when she was feeling very vulnerable, and her description of her health visitor as caring and capable is further enhanced by her overall impression that the health visitor was "on my side."

Deirdre (Int.18) also described her health visitor in very positive terms:

"She was lovely. I mean she really came in and gave me advice without making me feel that the baby wasn't really yours. It's something you kind of, we all know all about and you've got to learn. She didn't make you feel like that. It was like you know this is very much your baby and your child and always, you'll be fine and you're doing ok and. But not unrealistically so you know. She also recognised when you weren't doing OK. She was also very concerned about us as parents and our welfare and that was as important as Lucy's, particularly at the beginning. And she was very helpful on sort of the medical side because I was in so much discomfort from the birth and what not. And she was sort of person that would notice. Sometimes she would sort of notice and sort of ask me if you're feeling alright. She was tuned in, very tuned in. Em and she ran very good sessions for us, so that we could go up informally. And a number of my friends found that really invaluable." (Int.18: 664-679)

For Deirdre, the health visitor's ability to notice cues in the mother, her ability to advise without taking over, and her concern for the parents were important, as well as her role in facilitating social contact among parents.

Elsbeth (FG2) also appreciated her health visitor's ability to interpret cues about her emotional state:

"Yes, that's the most frightening thing about being a parent. Sometimes when I get angry with my children, or when John rolled off the bed, that someone would come and take my baby away, and it was the health visitor who worked out you were

feeling that way, and they can listen to you, and support you, and occasionally, perhaps, not say 'this is what you should do,' or have you thought of this, she can be tactful, and suggest things but make the options and possibilities available to you." (FG2: 373-382)

Elsbeth liked her health visitor's sensitive and non-directive approach when she was feeling vulnerable in her parenting role.

Parents also appreciated when the health visitor showed sensitivity, for example by realising when a mother did not want to discuss her depression in front of her partner, or by following up clinic visits with a telephone call and sometimes a visit when the health visitor sensed that a mother was requiring additional support. Sensitivity to parents' feelings appears to depend on the establishment of a good parent-health visitor relationship; for example, the lack of a relationship with a new health visitor was thought to be the reason why the latter did not realise that a mother was depressed (see section 6.9 p218), while Elspeth's health visitor, with whom she had established a good relationship, was said to be sensitive to her feelings of anxiety.

Parents described good health visitors as starting from the parents' perspective, having an "open approach" (Int.3: 521) as well as having their own agenda. Data analysis suggests that parents perceived good health visitors as acknowledging parents' unique understanding of their child and that any advice they gave had to be accepted, rejected or modified in the light of this understanding. This was demonstrated by health visitors suggesting a range of options with the qualification that the success of these strategies depended on the child, so that parents did not feel that it was their fault if the techniques did not prove successful. Shirley (FG1) explained:

"I went and she was good - she said try this, and made some suggestions. I could choose what to do in the end, but she gave me some good ideas to try and they worked. But it wasn't too prescriptive - she said try this, it might work, but every child's different. But I felt she had seen these problems many times before, and she knew what might work, and she made me feel that it was quite normal to have these problems. And sort of said it's nothing you're doing wrong. Children just sometimes have these problems, and lets see how we can sort it out, and I

felt better about myself, she said I was doing well and that I had a good understanding of my child and that made me feel good. I felt better about my confidence, and then I was able to deal with the problem easier, because I was felling better about myself too. It's a mixture of advice and support and a bit of a booster to your self esteem." (FG1: 278-292)

Shirley appreciated the combination of support and advice in addressing problems.

Similarly, Tracey (Int.10) liked her health visitor's consideration of her views and non-directive approach:

"Because like a lot of ma friends have already had kids and they're trying to tell me how to bring up ma kid. Whereas wi' <HV> she's no like that. She's listening to what you've got to say and then maybe advising you. If I'm doing something wrong then she'd say well look maybe you could do it this way. But not saying you've got to do it that way you know." (Int.10: 1026- 1031)

Although parents often preferred to have non-directive help with problems, sometimes when they had tried every option they could they were looking for direct advice, as Elspeth described:

"Well, I mean, I went to my health visitor with a toilet training problem and she retired shortly afterwards (laughter). And I said I cannot solve this problem, and she said 'Look, if I was in your shoes, this is what I'd do. Take him out of nappies at night completely, and if you can put up with the mess for a few weeks you'll solve the problem,' and it was someone saying to me, the way my mother would, 'look try this and as it was I ended up in hospital having number 2 and my mother sorted it out, and it worked. But that's the time when she said 'look, try this, just try it, I don't guarantee that it will work, but give it a shot,' and I thought 'she's right.' I needed someone to say to me 'look, it's time he went to the toilet,' instead of all this pantomime, and it worked, and sometimes it's just time to listen." (FG2: 449-461)

Elspeth had tried to solve her problems herself and by the time she approached her health visitor she was looking for direct advice. Sensitivity is therefore required by health visitors in order to provide a balance between direct and non-direct advice, and between giving practical ideas and using social persuasion in order to increase

parents' self-efficacy and hence their ability to work out their own solutions to problems.

Some parents appreciated being given help which took the context of the family situation, rather than standard advice for a situation. This was typified by a family who had a baby with some medical problems, where the hospital were seen as being concerned only with the baby, and the care he required, whereas the health visitor took account of all the other aspects of the family's position. Again, this sensitivity required a knowledge and understanding of family dynamics and circumstances, which could only be gained by building up a relationship with families.

Jasmine (Int.2) was impressed by the trouble her health visitor took to help her to work out a strategy to allow her to take her breast-fed baby to a wedding. Although this was very important to Jasmine, she thought it might not be considered so by the health visitor, as it did not directly affect the welfare of the baby and was concerned with the social side of her life rather than what she considered health-related issues.

Some parents said that they appreciated when their health visitor interacted with their child and gave some hands on care. Janette (FG5) recounted how her health visitor arrived by chance when she was very anxious because the baby was not feeding, and how the health visitor assessed the situation and gave her immediate practical and emotional support:

"Well the thing that was good aboot her wis em, mine was a baby that was in and oot of hospital as a baby - he had a lot of health problems and I was absolutely worried sick and he hadnae took a bottle and the door went and there was <HV> standing there at the right time and moment and she come in and she says "away and get yerself a cup of tea. I'll take the baby," and I'll give her her due, she says he's no sucking or anything he's no taking his bottle or anything, and I was just aboot in tears, and she seen to the baby, seen to calming me doon, and had everything a' settled and calm, that's how good she is so I cannae say anything bad aboot her." (FG5: 639-649)

Deirdre (Int.18) also recounted how her health visitor had a practical and hands on approach:

“She was very nice the way she handled Lucy as well. And eh she would pick Lucy up and try and help her with the colic. You know if she came out when she was colicky she wouldn’t just sort of leave it to me, she would show me ways of different things that I could do to try and relieve it.” (Int.18: 973-977)

Parents appeared to associate health visitors’ willingness to respond in a practical way with good health visiting practice and a caring attitude.

Good health visiting practice appeared to require sensitivity on the part of the health visitor in order to plan interventions appropriate to parents’ needs. Taking the contextual factors into account when working with families seemed to underpin good health visiting from the parents’ point of view. Good health visiting seems to depend on the establishment of a good parent-health visitor relationship which has already been shown to be enhanced by home visiting.

Bad health visiting

While the health visiting service was generally described in positive terms, some negative comments were made.

Some criticisms of health visitors referred to practical issues: cancelled appointments when parents had organised their own responsibilities around them or just the feeling of not being very important and health visitors not following up messages left on answering machines. Clinics were often considered busy and rushed as Joyce (Int.7) explained:

“I think they’re a bit under pressure mind, I wouldn’t like, I mean sometimes I feel when I go in there’s big crowds waiting and it can be quite difficult if you have got a problem you want to discuss it can be quite difficult because you know that they’ve got this crowd waiting outside and you really feel like you’re taking up a lot of time, there’s a lot of people with very small babies and they might also have problems you know, so I think they’re a bit overworked actually.” (Int.7: 335-342)

Some parents felt that health visitors were too focused on young babies and their parents and that they were “launched on their own” (Int.18: 570) too quickly. One professional mother whose practice population came mainly from an adjacent

deprived area felt that she was considered a low priority because of this, and that her problems were never really addressed.

Some parents were sceptical about certain aspects of health visiting advice, for example, to keep babies awake during the day, which was seen as impossible to follow. Parents who had given up breastfeeding early on felt generally that they had been pressurised into continuing, and were quite adamant that next time they would resist any pressure.

One parent who had gone back to work full-time said that she had lost touch with the health visitor because she was no longer able to attend the baby clinic, and felt that the health visiting service did not cater for dual-earner families.

Health visitors who made comments about areas outwith their remit were considered unfavourably, as Arlene (FG6) described:

“I never see my health visitor. My health visitor was mair interested in my dug. I had just got a pup and it was chewing the place up and I was training it and she saw the hole in the carpet at the front door and turned roond and she says ‘I’d get that shot’ so she got shot right and I never dealt with a health visitor since.” (FG6: 684-689)

Some parents believed that health visitors are “too nosey, wanting to know what going on in your life,” (FG5: 371) although surveillance of children’s welfare was also considered part of their role. In contrast to parents’ understanding of good health visiting practice, health visitors who implied that failure of suggested strategies was due to parents’ inadequacies were viewed negatively by parents.

Some parents felt that they were expected “just to get on with it,” (Int.12: 726) and others who felt brushed off when they approached a health visitor did not do so again. This was particularly the case when parents had had a good experience with one health visitor and had then moved on to another one who did not seem as interested as the first one.

In some cases advice was seen as too direct but in other situations parents wanted more specific advice, and found the health visitor’s approach too non-directive as Catriona (Int.12) explained:

RH- "So is there anything you think the Health Visiting Service could provide, I mean. Some people say really good things about what they want, so can you say what you help you could have done with or could do with just in general terms?"

Catriona- "I think a bit, well positive's not the right word, because they are very positive, but still very, I know they're trying not to tell you what to do and what not to do but it's all 'well, you know, whatever you want to do'"

RH- "More direct advice then?"

Catriona- "You feel ' just *tell* me what to do' rather than this you know. She was too wishy-washy." (Int.12: 795-805)

The importance of sensitivity to parents' needs in relation to advice-giving has already been discussed earlier in this section in relation to good health visiting, from the perspectives of parents, and this comment demonstrates the effect of the wrong approach on the parents. The parents who made this comment also believed that they had not had the support from the health visitor they deserved and had only had one home visit shortly after the birth; they therefore had not built up a relationship with her and their needs were unlikely to be interpreted fully.

Most examples of parents' dissatisfaction with the health visiting service involved lack of support and advice because families' needs were not identified or were not addressed in ways considered helpful by parents, while a few were due to parents not wanting involvement with the service.

6.12 Summary and discussion

Many parents appeared to believe that health visitors have a duty to monitor the welfare of all children, as 'social policemen' (Abbott and Sapsford 1990), whether or not they have been identified as being at risk. Parents' views conflict with proposals for changes in health visiting practice from providing a universal service to targeting families with identified problems (Audit Commission 1994; Goodwin 1988). However many parents described their own health visitors as providing them with support and encouragement and as having a role in substituting to some degree for support and advice which traditionally might have come from parents' own social

network of family and friends. This understanding of the health visiting service differs from that proposed by McIntosh (1986), whose study participants had good family support and previous experience of childcare, and who mainly saw the health visitor in terms of surveillance. The health visitor was considered by participants in the present study to be an expert on childcare and children's minor illnesses. The health visiting service was also portrayed as an important source of advice to some parents who had good social support, as a resource for help with problems which could not be resolved with help from informal sources. This finding supports the preservation of health visiting as a universal service. While the health visitor's role with families in the early days of parenthood was generally well understood, parents' recognition of the wider remit of the health visiting service often depended on personal or second-hand experience of health visitors providing more holistic care. Home visits and antenatal contacts appeared important to parents in the establishment of good relationships between parents and health visitors, leading to interventions being tailored to the families' individual circumstances. Caring, as defined by Leininger (1991) and Benner (1984) (see Chapter 3.11 p86) emerged from analysis of the data as being an important aspect of the health visitor's role with families. The health visitors who were involved with the parents in this study appeared to be providing a service which was responsive to the needs of their clients in spite of the general move towards targeting interventions to families assessed as vulnerable in terms of child protection issues as discussed in Chapter 3.8.

CHAPTER 7: THE CONCEPTUAL FRAMEWORK

7.1 Introduction

Theories and conceptual models are created by researchers by pulling together and making sense of observations and existing knowledge. Polit and Hungler (1999) highlight the ways in which theoretical frameworks help to progress knowledge, their overall purpose being to make research findings meaningful and generalisable. They allow researchers to knit together observations and facts to create an orderly pattern and they draw together and summarise findings of separate studies; this allows accumulated knowledge to become more accessible and useful both to practitioners in their practice and to researchers to further develop knowledge. Theories “help to stimulate research and the extension of knowledge by providing both direction and impetus” (Polit and Hungler 1999 p111). Berg (1995) discusses the issues surrounding the use of theory in the research process. While some argue that ideas and theory must precede the research being carried out, others, such as Merton (1968), suggest that research initiates, reformulates, deflects and clarifies theory. Berg (1995) advocates that rather than using one or other approach, both of which are based on a linear progression, theory can be used at any or all stages of the process, with the theoretical framework modifying and being modified by the literature review, research design and data collection and analysis. Parahoo (1997) suggests that the term ‘theoretical framework’ is best reserved for research underpinned by one identified theory, while ‘conceptual framework’ uses various theories. In the present study, while concepts identified by the literature review were explored throughout the study, only after completing the thematic analysis were three selected to facilitate the interpretation of the findings of the study.

7.2 Key concepts arising from the data

The thematic analysis revealed three main concepts: the inherent stress associated with parenthood and parents’ ability to cope with stress, the processes involved in

learning the skills of parenting and the interaction of parents with social systems including family and friends, work and professionals.

Stress was associated with the responsibility felt by parents for their children (see Chapter 5.2 p119), with the transition to parenthood especially problematic (see Chapter 5.3 pp119-120) and concerns about effective ways of disciplining children without using physical punishment also causing anxiety. Parents' stress and coping appeared to be affected by the availability of social support. The health visiting service was also seen by some parents as helping parents to cope, and health visitors were believed to assess families in terms of stress and coping (see Chapter 6.4 p207), with those seen as being more vulnerable being offered more health visiting interventions, which could involve reassurance (see Chapter 6.8 pp213-214) and showing sensitivity to parents' feelings of stress and inability to cope (see Chapter 6.11 p227).

Concepts relating to parents' acquisition of parenting skills were also evident in the analysis. Parents appeared to learn from their own experience (see Chapter 5.14 pp174-178 and 5.17 pp193-194), from that of others (see Chapter 5.15 pp178-190) and by gaining confidence in their role, which was seen as often being facilitated by health visitors (see Chapter 6.8 pp213-214 and 6.11 pp224-230).

The interaction of parents with family (see Chapter 5.11 pp156-169 and 5.15 pp178-185), friends (see Chapter 5.12 pp169-174 and 5.15 pp185-189) and professionals (as presented in Chapter 6), appeared to affect parents' experience of their role, the mediation of the stress inherent in childrearing and the attainment of parenting skills. The role played by the health visiting service in families' lives was also seen to depend on the availability of other sources of support and information. It was also important for health visitors to consider the family as a unit of care and to look at relationships within the family and between the family and its wider social network.

A single theory was not found which adequately explained the concepts described above and it was decided that the findings would be most fully interpreted using a conceptual framework which incorporates three theories. Lazarus and Folkman's (1984) theory of stress and coping, Bandura's (1977, 1986) theory of social learning

and family nursing are now described before going on to discuss the rationale for using them in the interpretation of the findings.

7.3 Lazarus and Folkman's (1984) theory of stress and coping and its relevance to the study

The literature review has depicted parenthood as purposeful but problematic. The association with parenthood of concepts such as distress and tension (Cowan and Cowan 1988), suggest that stress is commonly an inherent aspect of parents' lives and that coping strategies are important in enabling parents to fulfil their role. The findings also highlight the stress experienced by parents of young children. Lazarus and Folkman's (1984) theory of stress and coping was used in the present study as part of the conceptual framework for the interpretation of the findings because it acknowledges coping in its own right rather than as an adjunct to stress. A summary of the model can be found in Table 1 (p237).

Lazarus and Folkman (1984) define stress as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p19).

Two critical processes mediate the person-environment relationship: cognitive appraisal and coping. Cognitive appraisal is "the process of categorising an encounter, and its various facets, with respect to its significance for well-being" (p31). Lazarus and Folkman differentiate between *primary appraisal* and *secondary appraisal*.

Three kinds of primary appraisal are distinguished: irrelevant, benign-positive and stressful. An encounter with the environment is considered irrelevant if it has no implication for a person's well-being. Benign-positive appraisals occur if the outcome of an encounter is construed as positive, and is judged as preserving or enhancing well-being or having the potential to do so. Benign-positive appraisals are characterised by pleasurable emotions such as joy, love, happiness and exhilaration, although most benign-positive appraisals are tinged by some degree of apprehension. Stress appraisals include harm/ loss, threat and challenge. In harm/ loss some damage

Table 1: Synopsis of Lazarus and Folkman's (1984) Theory of Stress and Coping

COGNITIVE APPRAISALS

Primary

Irrelevant

Benign/ positive

Stressful

a) harm/ loss

b) threat

c) challenge

Secondary

Assess:

coping options

likelihood of options succeeding

opportunities for applying strategies

COPING

Problem-focused (changeable)

1. Define problem

2. Look for solutions

a) environment- alter barriers, pressures and procedures

b) develop new skills and behaviour

c) reappraisal - change levels of aspiration

d) confront, accept responsibility, plan solutions, selectively attend to positive aspects

Emotion-focused (not changeable)

Reappraisal of situation

Selective attention

Avoidance

Seeking social support

Distancing

Emphasising the positive

RESOURCES FOR COPING

Health and energy

Positive beliefs

Problem-solving skills

Social skills

Social support- emotional, tangible and information

Material resources

CONSTRAINTS

Personal - unwillingness to use social supports

Environmental - scarcity of resources

OUTCOMES

1. Social functioning

2. Morale and life satisfaction

3. Somatic health

to the person has already occurred, while threat concerns harms or losses which have not occurred but are anticipated, and thus gives scope for anticipatory coping. Challenge appraisals, like threat, requires coping strategies to be used, but focus on the potential for gain or growth, and are characterised by pleasurable emotions such as eagerness, excitement and exhilaration. Parenthood is likely to be appraised as challenging by most parents, being a source of both meaning and difficulties.

Secondary appraisal involves evaluating what might and can be done, and is a complex process which assesses which coping options are available, the likelihood that coping options will succeed, and the opportunities for applying strategies effectively. Lazarus and Folkman define vulnerability, which is a concept commonly referred to in the study of stress and adaptation, as the relationship between the individual's pattern of commitments and his or her resources for warding off threats to these commitments. The greater the strength of the commitment, the more vulnerable the person is to stress in the area of that commitment. Parents would therefore be considered to be potentially vulnerable in view of the feelings of responsibility that parents associate with bringing up their children (see Chapter 2.4).

Lazarus and Folkman (1984) define coping as "constantly changing cognitive and behavioural efforts to manage specific external and/ or internal demands that are appraised as taxing or exceeding the resources of the person" (p141). Lazarus and Folkman refer to two types of coping, problem-focused coping when there has been an appraisal that conditions are amenable to change, and emotion-focused coping, when the person has appraised the situation as not being amenable to change. Coping has two major functions: the regulation of distressing emotions (emotion-focused coping) and doing something to change for the better the problem causing the distress (problem-focused coping). Folkman and Lazarus (1980) found that both functions of coping were represented in over 98% of the more than 1,300 stressful encounters that were reported by 100 middle-aged men and women over the course of a year. Parents could therefore use emotion-focused coping strategies by learning strategies to minimise the impact of stress caused by children and problem-focused coping to work out practical solutions to difficulties associated with their role.

Emotion-focused coping sometimes involves reappraisal of the situation, leading to a change in the way a situation is construed, without changing the objective situation. Other forms of emotion-focused coping such as selective attention, avoidance, and seeking emotional support may lead to reappraisals but are not in themselves reappraisals. Problem-focused coping involves defining problems and looking for solutions, either in the environment, by altering barriers, pressures and procedures, or in the person, developing new skills and developing new behaviour. Problem-focused coping can also involve reappraisals, such as changing levels of aspiration. Emotion-based modes of coping can facilitate problem-based coping if they are used to manage emotions that would otherwise impede problem-focused activity (Lazarus and Folkman 1984). Folkman et al (1986) showed that more problem-focused forms of coping were used in encounters appraised as changeable, and more emotion-focused forms of coping were used in situations where there appeared to be few if any options for affecting the outcome. In changeable encounters, people use coping strategies which keep them focused on the situation: they confront, accept responsibility, plan solutions and selectively attend to the positive aspects of the encounter. In contrast, when subjects appraise encounters as having to be accepted, they turn to distancing and escape-avoidance, which are forms of coping that allow the person not to focus on the stressful situation. Lazarus (1995) suggests that the success of secondary appraisal (appraisal of the options for coping) depends to some extent on an accurate assessment of the degree to which change is possible, and quotes the motto of Alcoholics Anonymous: "God grant me the courage to try to change what can be changed, the serenity to accept what cannot be changed, and the wisdom to know the difference." It would therefore appear that parents would benefit from learning to differentiate between situations which are amenable to change and those where they must cope with the situation as it is.

The ability to cope with a stressful situation depends on the resources available, including health and energy, positive beliefs, problem-solving skills, social skills, social support and material resources (Lazarus and Folkman 1984). These factors are

likely to vary significantly between families and some families may therefore be much better placed to cope with family life than others.

A person's ability to deal with a situation may be constrained by factors which arise from personal agendas, such as an unwillingness to use available social support or from the environment, due to scarcity of resources.

The prime importance of appraisal and coping processes is that they affect adaptational outcomes. Outcomes are of three types: functioning in work and social living, morale and life satisfaction, and somatic health. In other words, the quality of life and mental and physical health depend on the ways in which people evaluate and cope with the stresses of living. Parents' coping abilities would therefore be likely to affect family functioning and dynamics.

The effectiveness of coping strategies depends on the extent to which they are appropriate to the internal and/ or external demands of the situation. Coping effectiveness also depends on the appropriateness of primary and secondary appraisals, that is the realistic judgements about the implications of a situation and the options for dealing with the situation. The degree of balance between emotion-focused coping and problem-focused coping contributes to coping effectiveness. Regulating emotions successfully without dealing with the source of a problem, and managing a problem effectively at great emotional cost, are not effective coping strategies. Lazarus and Folkman acknowledge the fact that not all situations can be coped with effectively.

For coping to be effective, there must be a good match between coping efforts and other agendas, such as values, goals, commitments and beliefs. When coping strategies conflict with strongly held personal values they present new sources of stress, and are also likely to fail because of lack of conviction. Parents therefore have to work out ways of reducing their stress which do not compromise their own aims and aspirations for themselves and their children.

Lazarus and Folkman (1984) discuss social functioning in terms of the ways in which the individual fulfils his or her various roles, for example, as a parent, spouse or job-holder. Social functioning within the family is likely to depend both on parents'

perceptions of themselves as parents and also on relationships between parents and between parents and children; dual-earner families might be expected to experience some difficulty with respect to managing careers and family life and the conflicting social expectations of each role.

In relation to morale and life satisfaction, according to Lazarus and Folkman (1984), coping becomes extremely important as the mechanisms through which a positive sense of well-being can be sustained in adverse conditions. This can be achieved through positive comparisons, in which the individual argues that the situation could be considerably worse, and what Mechanic (1962) described as “comforting cognitions,” the seeking out of information from the environment which is consistent with the individual’s hopes and attitudes. Morale depends on the relationship between expectations and the encounter outcome. In the long-term, positive morale depends on a consistent tendency to appraise encounters as challenges, or to appraise harms and threats as manageable and even productive, and to tolerate negative experiences.

Coping, according to Lazarus and Folkman (1984), can affect somatic health in three ways. Firstly, poor coping can increase neurochemical stress reactions and it can also increase the risk of mortality and morbidity when it involves the use of substances such as tobacco and alcohol or participation in high-risk activities in the attempt to ameliorate stress. When emotion-focused forms of coping are used inappropriately health can be impaired by impeding adaptive health/ illness-related behaviour, for example by parents denying the impact of children on their lives and trying to continue to maintain their previous pace at work and in their social activities.

The social environment can create stress in the form of social demands (Lazarus and Folkman 1984), through conflict, ambiguity and overload. Conflict occurs when an individual has to make compromises in one role in order to fulfil another. Ambiguity occurs when expectations of a role are unclear. Overload is caused by too many roles being expected of one individual. The social environment, as well as creating social demands, is also the source of social support, “vital resources which the individual

can and must draw upon to survive and flourish” (Lazarus and Folkman 1984 p243). Social support is thought to prevent stress by making harmful or threatening experiences less consequential, or provide valuable resources for coping when stress does occur. Lazarus and Folkman (1984) distinguish three types of functions of social support, as defined by Schaefer (1982): emotional support (including attachment, reassurance, being able to rely on and confide in a person), which contributes to the feeling that one is loved or cared about; tangible support (involving direct aid and services); and information support (providing information or advice, and giving feedback about how someone is doing). Lazarus and Folkman (1984) consider social support to be a resource, which the person must cultivate and use.

Traditional approaches to stress, coping and adaptation have used a unidirectional model. Lazarus and Folkman (1984) propose a transactional model, where the person and the environment are viewed in a dynamic, mutually reciprocal, bidirectional relationship. The emphasis is on change, which is necessary in order to restore harmony. Strategies to change the environment are as appropriate as those designed to change the person, with the aim of establishing increased harmony between the person and the environment.

Folkman and Lazarus (1985) assessed coping strategies used by a group of students at three stages of an examination: before the exam, waiting for results and after the results were announced. Before the examination, problem-focused coping was at its height, as students studied. Two forms of emotion-focused coping, emphasising the positive and seeking social support, were also at their height at this time. While waiting for the examination results, there was a large decrease in problem-focused coping, seeking social support and emphasising the positive and a large increase in distancing, reflecting the fact that nothing more could be done to influence the outcome of the examination. After the examination results were announced, students who had received lower grades reported using more emotion-focused forms of coping than those who had been more successful. It seems likely that parenting may involve different types of coping behaviour depending on the developmental stage of both the child and the parents.

As well as considering mechanisms at different stages of a stressful encounter, Lazarus (1995) proposes that any source of stress may produce diverse threats or challenges, which require a range of coping strategies. He uses the illustration of a woman after mastectomy, who may be coping with the likelihood of recurrence of the malignancy, or with dealing with the effects that the disease has had on her children or work. It may therefore not be useful to talk about stress and coping associated with breast cancer, but to specify and address the specific threats of concern to the patient. Lazarus (1995) puts forward the argument that "the process of coping employed for the different threats produced by cancer, or any other complex source of psychological stress, whether disease based or not, varies with the diverse adaptational significance and requirements of these threats" (p236). When considering stress in relation to childrearing, it would therefore be vital to assess each family individually to understand the sources of stress for that particular family.

Pearlin and Schooler (1978), in a study of coping in relation to marriage, parenting, household economics and occupation, showed that the greater the scope and variety of the individual's coping repertoire, the more protection coping affords. With relatively impersonal stresses, such as those stemming from economic or occupational situations, the most effective forms of coping were found to be the manipulation of goals and values in a way which psychologically increases the distance of the individual from the problem. On the other hand, problems arising from the relatively close interpersonal relations of parental and marital roles were found to be best handled by coping mechanisms in which the individual remains committed to and engaged with the relevant others.

Use of the stress and coping model in relation to parenting

While most of the literature about stress and coping concerns the study of essentially negative and non-normative life events, parenthood is considered to be a normative event for most people. Although Lazarus and Folkman's (1984) theory has been used to explore how parents cope with the demands of children with special needs, a literature search revealed only one study in which the theory was applied to 'normal' families.

Levy-Shiff et al (1998) used Lazarus's model of stress and coping in a study of the process of adaptation to parenting, involving 140 primiparous mothers. Parents were assessed during pregnancy, and at 1 month, 6 months and 12 months post-partum. They found that parenting is a dynamic process with cognitive appraisals and coping strategies changing over time. Parents tended to use a combination of all available coping techniques at each stage, which the authors propose is a response to different aspects of parenting. Problem-focused efforts were found to increase with time, emotion-focused efforts remained relatively stable, and the seeking of social support declined over time; parents therefore appear to become more competent and confident in relation to solving problems with experience.

7.4 Bandura's (1977, 1986) Social Learning Theory and its relevance to the study

Bringing up children requires the acquisition of relevant skills by parents. Formal education in parenting is very limited and parents must rely on other means to develop their expertise. Bandura's social learning theory (1977, 1986) provides a useful framework for the consideration of the processes involved in learning the skills of childrearing.

According to Bandura (1977), human functioning is determined by the interaction of behaviour, cognitive and other personal factors and the environment. The three factors will vary in the amount of influence they exert for different individuals, activities and circumstances. The theory provides a useful framework for exploring the ways in which parents learn the skills they require to care for their children.

Observational learning (vicarious experience)

Much social learning occurs by observing others and the consequences of their actions. Learning by modelling enables people to reduce the amount of time and effort which is required to master skills, compared with learning by experience, and minimises the risks associated with mistakes. Observers can acquire cognitive skills and new patterns of behaviour by observing the performance of others. New behaviour patterns, judgmental standards, cognitive competencies and generative

rules for creating behaviours can be learned. Modelling influences teach component skills and provide rules for organising them into new patterns of behaviour. Motivation can be altered by seeing the results of the efforts being modelled. It would therefore be expected that parents who had had considerable experience of children, perhaps by growing up surrounded by a large extended family, would be more competent in childrearing than those who had had little contact in the past.

Enactive learning

Some cognitive skills are learned from experience, and many which are acquired through modelling are refined and modified experientially. Rules are formulated which produce desired outcomes, and are refined in response to the results obtained. Inducing rules from enactive performance depends on the individual's knowledge base and on the ability to use effective strategies for quickly narrowing down possible solutions to the appropriate ones. Learning from enactive experience does not ensure that the best alternatives will be sought and developed. Most situations do not involve dichotomous outcomes in which a specific course of action either works or fails; rather, different solutions are possible, which vary, often widely, in adequacy. Once a satisfactory solution has been found, people are unlikely to look for an even better one. Enactive experience therefore tends to produce adequate rather than optimal skills. Schwartz (1982) found that once people hit on a solution that works, they keep using it without considering other alternatives. However, challenges to discover optimal solutions encourage more exploratory thinking and strategies for action. Experience is most useful for learning skills when the effects are salient, powerful and show their effects immediately, which is unlikely to be the case in most situations encountered by parents, for example, in managing children's behaviour. Whereas in observational learning, models help observers to infer judgmental rules by demonstrating how to select the predictors from the available information and how to combine them to form the correct course of action, in enactive learning people have to figure out everything on their own, with only the positive and negative effects of their actions for guidance. Learning parenting skills by 'trial and error,' apart from occasionally being hazardous for the child, is likely to

be tedious and by the time the skills for a particular stage of a child's development have been acquired, it is likely that the next phase will have been reached.

A mixture of enactive and observational learning is likely to be the most effective way for parents to gain childrearing skills.

Self-efficacy

According to Albert Bandura (1986), perceived self-efficacy is a person's appraisal of his or her ability to perform effectively or competently in a given situation. Bandura (1986) distinguishes between outcome expectancy, the person's evaluation that a given behaviour will lead to certain outcomes, and efficacy expectation, the person's conviction that he or she can successfully execute the behaviours required to produce the outcomes. A strong sense of self-efficacy is necessary for a sense of personal well-being and allows for persevering in efforts towards success. Individuals with greater self-perceptions of efficacy are able to channel their attention and resources towards mastering the situation at hand. Conversely, individuals with lowered self-efficacy channel their energy towards worrying about negative outcomes. Lowered self-efficacy may also increase an individual's vulnerability to stress and depression (Evans 1989). Self-efficacy is therefore likely to affect both parents' performance as parents and their own mental health, independently and interdependently.

Self-efficacy, in relation to specific situations, is enhanced or influenced by four different mechanisms, identified by Bandura (1986) as mastery experiences, modelling, social persuasion and judgement of bodily states.

Mastery experiences are considered to be the most influential sources of efficacy information. One's belief in self-efficacy may be enhanced or diminished by past experiences of success or failure.

Modelling (vicarious experiences) provides inspiration and skills on how to succeed in tasks, and is especially important for individuals who are tackling a new task and thus have no previous experience. This suggests that it is important that parents with little experience of childcare have contact with other parents.

Social persuasion, deriving from social support and realistic encouragement, contributes to performance by motivating an individual to work harder towards success. According to Bandura's theory, encouragement from family, friends and health professionals would also increase parents' self-efficacy.

Finally, judgement of bodily states may affect self-efficacy; Bandura perceives stress, defined as somatic arousal, to be an ominous indication of vulnerability towards failure and thus a cause of decreased appraisal of self-efficacy. Thus, the early days of parenthood, described by LeMasters (1957) as a crisis (see Chap 2.3 p15), are likely to be characterised by low levels of self-efficacy. Health visiting interventions aimed at providing mastery experiences, by helping parents to identify their successes, are likely to be of particular benefit to parents in these early days.

Use of Bandura's social learning theory in relation to parenthood

Within nursing research, Bandura's social learning theory has been used to explore self-efficacy in parents. Teti and Gelfand (1991) assessed behavioural competence and self-efficacy in 86 mothers, half of whom were depressed, over the first year of life of their infants. The authors found that higher self-efficacy was positively associated with social-marital support and negatively with maternal depression and infant difficulty. The depressed mothers had lower self-efficacy, lower support and lower parenting competence. Self-efficacy was found to be the variable most related to parenting competence. These findings support two premises of Bandura's theory of self-efficacy: that social persuasion in the form of social and marital supports positively influences parenting self-efficacy and that psychosocial variables such as depression and infant difficulty have inverse relationships to self-efficacy. The authors propose that social support also increases self-efficacy by providing vicarious experiences.

Gross et al (1989) looked at maternal confidence, or mothers' self-perceptions of effectiveness in managing their toddlers using quantitative measures of self-efficacy and involving the mothers of 210 toddlers. Their findings support Bandura's concept of mastery experiences, in that prior child care experience correlated highly with maternal confidence. This has implications for contemporary families, where

previous experience of caring for children is less usual than it was in the past when large extended families were the norm.

Cutrona and Troutman (1986), in a study involving 55 women, designed a model linking maternal social support and infant temperament to postpartum depression through their effects on self-efficacy. Supporting Bandura's theory, social support had positive relationships, and difficult infant temperament had negative relationships with parenting self-efficacy. The authors however, caution that the relationship between social support and self-efficacy could be explained by the fact that individuals who have high self-esteem may be more attractive to others and hence find themselves surrounded by people willing to offer support. As Cutrona and Troutman (1986) point out, this explanation would be in accordance with Gottlieb (1981) who places emphasis on personal resources rather than on the availability of social resources.

McBride (1989), in a study of 94 fathers of pre-school children, found significant inverse relationships between stress in the parenting role and parenting competence. For fathers, depression and perceptions of difficulty of the child predicted parental competence. Again, these findings support Bandura's theory that stress has a negative effect on self-efficacy.

These studies therefore support the use of Bandura's theory of social learning in the exploration of the experience of parenting.

7.5 Family nursing

Family systems theory

Lazarus and Folkman's (1984) theory of stress and coping and Bandura's (1977, 1986) social learning theory provided a framework for the interpretation of the experience of parents with young children and of the ways in which parents learned childrearing skills. Family nursing theory was found to be useful in interpreting both these processes and also in understanding the role of the health visiting service in relation to parents of young children.

'General systems theory' was initially formulated by the biologist von Bertalanffy in the 1920's and was then developed by mathematicians, engineers and others before being applied to social organisations, including small groups, the family and whole societies (Bertalanffy 1968). As Frude (1990) suggests, systems theory is better at providing descriptions than at making specific predictions about families and is probably more appropriately viewed as a conceptual tool than as a testable theory. This approach to the study of the family provides a valuable insight into the complexities of family life. Although family systems theory originated as a tool to facilitate family therapy with families experiencing problems, the principles apply equally well to all families and appear to provide a useful basis for health promotion.

A system is a set of elements, the relationships between them and the relationships between attributes of the elements (Frude 1990). Systems theory uses the concept 'circular causality' to explain the ways in which a cause produces an effect which then has many repercussions, some of which have an effect on the original cause. Observation of the system confers some degree of 'stasis' on a system which is in reality highly dynamic and interactive. Information is transmitted within the system and is used to maintain stability, to bring about change and to facilitate interaction with other systems. A system is a structure of elements, each of which is likely to have different roles within the system, depending on its intrinsic characteristics and its position within the system. Within each family system, several sub-systems may be identified, and the family system constitutes part of much larger supra-systems.

Each system, subsystem and suprasystem has a recognisable boundary (Minuchin 1974). Boundaries may be open, allowing some exchange with the environment, or closed, or impermeable to the environment. Most family systems are semi-permeable, with clearly defined boundaries but allowing exchange between members within the system and with the outside environment.

Family systems theory is used to explain mechanisms both of maintaining stability and effecting change (McCubbin and Patterson 1983). Stability is maintained by homeostatic mechanisms which initiate adjustments in family structure and functioning and thereby bring the family back to its original state, using negative

feedback. Change occurs when there is a positive feedback response and the family adapts to a new structure and mode of functioning. This process, known as morphogenesis, takes place both when major adjustments are necessary, for example during the transition to parenthood, and at a more subtle level in response to minor changes in family structure and functioning such as in response to different stages of children's development or to accommodate the addition of more children to the family unit. Morphogenesis can result in bonadaptation, when the family functions better than before, recovery to the previous level of functioning or maldaptation when the family functions less well than previously.

Olson and McCubbin (1983) built on family systems theory to create the Circumplex Model of Families. This model includes three further aspects of family life: cohesion, adaptability and communication. There are four levels of cohesion: disengaged (very low), separated (low to moderate), connected (moderate to high) and enmeshed (very high). The two extreme levels are considered to be problematic, with enmeshed families preventing members having their own identity, and disengaged families having little sense of family unity. The four levels of adaptability, which reflects the ability of families to change are: rigid (very low), structured (low to moderate), flexible (moderate to high) and chaotic (very high). As with cohesion, the extreme levels of adaptability are considered to be problematic. Communication is considered to be a facilitating dimension, which promotes cohesion and adaptability.

Carter and McGoldrick (1988) describe a family life cycle which provides a way of seeing family functioning and change developmentally. They present six stages in the family life cycle: single young adults, new couples, families with young children, families with adolescents, launching children and moving on and families in later life. As families make the transition from one stage to another, families have to confront a number of issues and tasks, almost always involving morphogenesis. The transition to parenthood involves creating a shared image of family life, which will be affected by the functioning of the families of each parent.

Family systems theory appears to provide a useful approach to understanding family dynamics and functioning, and highlights the major changes instigated by a major

life transition such as the birth of a child. The importance of establishing good family functioning and the potential for difficulties arising are also exposed by this conceptual framework.

Family nursing

The concepts used in family systems theory have been developed in order to apply this approach to nursing practice. Family nursing involves three levels of intervention: “nursing of the system of individuals, the system of dyads, triads and larger groups, and the entire family system” (Friedemann 1989, p211). According to Whyte (1997) family nursing at the individual level focuses on the health and well-being of individual members of a family, at an interpersonal level the nurse focuses on two or more individuals and the relationships between them while family systems nursing involves working with the whole family system and may involve addressing issues within the family and with their interaction with their environment. Whyte (1997) makes the point that this approach involves working *with* families, focusing on their strengths rather than problems, and helping families to identify their own solutions rather than imposing the nurses’ assessment of and solutions to a family’s situation. Whyte (1997) clarifies the terminology by suggesting that family nursing be used synonymously with the North American term family systems nursing. She also differentiates between family focused and family-centred care, where the individual is the patient/client but assessment is made and interventions planned within the context of the family, and family nursing, where the family is the unit of care although interventions may take place at an individual and interpersonal level.

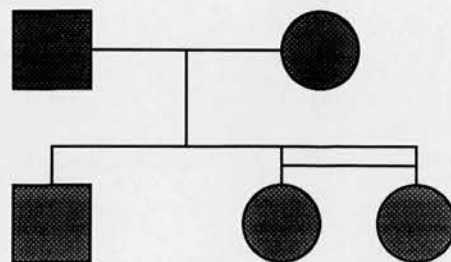
In defining the family, Wright proposes that “the family is who they say they are” (Wright and Leahey 1994, p40) and Frude (1990) calls for non-traditional family groups and cultural diversity in family life to be acknowledged when defining family systems. Whyte (1997) highlights the need for nurses to be aware of the cohesiveness of the family and an awareness that in some families it may be necessary for individuals to isolate themselves from their family system in order to identify and address difficulties. She also proposes that the nurse should explain the rationale behind family nursing in relation to needs assessment and the planning and delivery

of care. A family assessment involves helping the family to understand their family structure, development and functioning (Whyte 1997). The genogram (Figure 1 p254) is a graphical representation of family structure, which may focus initially on the nuclear family and gradually be expanded to include extended family and friends. The ecomap (Figure 2 p254) represents the family's significant contacts and places the family in the context of the environment. The genogram and ecomap are drawn up with the family to portray the family structure, supports and stresses and allow both the family and nurse to understand the family dynamics while building up a relationship. Whyte (1997) calls for sensitivity on the part of the nurse in recognising the extent to which families feel comfortable about disclosing details of their family life. Referring to the work of Wright and Leahey (1994), Whyte (1997) suggests that moving from assessment to intervention involves working with families to identify strengths and problems, looking at these from the point of view of the whole family, and recognising that not all families require intervention and not all problems require resolution. Interventions of particular use in family nursing include emphasising the strengths of families, providing information, circular questioning which relates questions about the functioning and relationships of the whole family, reframing situations by offering other possible viewpoints and interpretations, and agreeing on goals and tasks to address identified problems. The family nursing process ends with evaluation consisting of reflection, validation and future planning being carried out in partnership between the nurse and the family.

7.6 Justification for the conceptual approach

While Lazarus and Folkman's (1984) theory of stress and coping and family nursing each have the potential to provide a framework for the interpretation of the findings, it was felt that the involvement of both theories would facilitate a better understanding of the findings and provide a more useful platform for future research aimed at developing health visiting practice. Bandura's (1977, 1986) theory of social learning also provides a fuller understanding of the processes involved in learning the skills of parenting than do the other two theories.

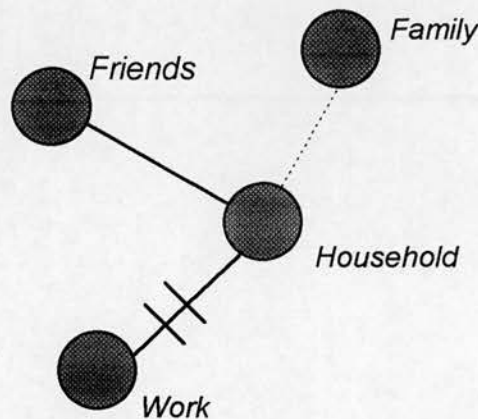
Figure 1: Genogram



Adapted from Whyte (1997)

Squares denote males and circles females. Figure 1 depicts a father, mother, son and twin daughters. Other symbols are used to depict events such as divorce, adoption and miscarriage. The genogram can be built up to include extended family and friends.

Figure 2: Ecomap



Adapted from Whyte (1997)

The ecomap represents the family's significant contacts and places the family in the context of the environment. The dotted line indicates a tenuous relationship, and the crossbars signify a stressful relationship. The ecomap can include relationships with others such as nurseries, professional agencies and church.

The common factors of the theories are now discussed before proceeding to identify differences.

Environmental factors feature in each of the theories used in the study. Lazarus and Folkman (1984) propose a transactional model of stress and coping, integrating both the individual and the environment, and involving the processes as well as the structures. Likewise, family nursing theory places the family within its environment and its stresses and resources. The opportunities for modelling and social persuasion, according to Bandura's theory of self-efficacy, also depend on environmental factors. The main common factor in the environment is social support, which is proposed as a resource for coping by Lazarus and Folkman (1984), for increasing self-efficacy by Bandura (1986) and for promoting good family functioning in family nursing.

Each of the theories also refer to internal factors which affect family functioning. Lazarus and Folkman (1984) identify health and energy, positive beliefs, problem-solving skills and social skills as resources which come from within the family. Family nursing theory involves helping families to identify their internal strengths and weaknesses, and to consider how members of the family relate in terms of cohesion, adaptability and communication to one another as well as with others outside the immediate family. Bandura (1986) identifies self-efficacy as an internal factor which affects an individual's ability to carry out tasks.

The three theories feature change. Lazarus and Folkman's (1984) transactional model emphasises changes in both the person and the environment to establish consonance, while family nursing addresses morphogenesis and its outcomes. Social learning involves changes in self-efficacy through various processes.

While family models such as McCubbin and Patterson's (1983) model of stress and adaptation provide important insights into the dynamics of family life, they are limited in terms of stress and coping in several ways. As noted by Beresford (1994), Lazarus and Folkman's model puts equal emphasis on stress and coping, whereas the family models concentrate on stress as the primary concern, and also advocates the role of intra-personal and socio-ecological factors in mediating the effects of stress.

This strengthens the argument for using Lazarus and Folkman's (1984) theory of stress and coping as well as family nursing theory.

The strength of family nursing appears to lie in the interpretation of health visiting interventions with families with its emphasis on the whole family as the unit of care. Both the review of the literature and the analysis of the data support this approach and it therefore seems useful to reflect on the findings in terms of family nursing in order to explain health visiting practice.

Bandura's (1977, 1986) theory of social learning adds to the application of Lazarus and Folkman's (1984) theory of stress and coping to parenthood in facilitating the processes involved in parents' acquisition of childrearing skills. Self-efficacy as defined by Bandura (1986) is synonymous with positive beliefs as included by Lazarus and Folkman (1984) as a resource for coping. However, the ways in which self-efficacy is achieved are made very explicit by Bandura, who also gives more detailed attention to the development of new skills and behaviour.

The conceptual framework provides a basis for interpretation of the findings with the aim of developing health visiting practice in relation to working with families with young children.

CHAPTER 8: DISCUSSION

8.1 Introduction

The study set out to explore parents' experience of bringing up young children and of the health visiting service within the context of the day-to-day life of families with young children. Since the study was undertaken, there has been an increased focus on both parenting and consumer involvement in the health service in Scotland, with the policy recommendations of the White Papers, *Designed to Care* (Scottish Office 1998), *Towards a Healthier Scotland* (Scottish Office 1999a), and *Our National Health* (Scottish Executive 2000a).

The literature relating to parenting and to the relevant aspects of health visiting has been reviewed and the findings of the study presented. This, the final chapter, is devoted to discussing the findings of the study. Firstly, the limitations of the study are discussed. Then the findings are discussed in relation to the conceptual framework presented in the previous chapter. The chapter concludes by addressing issues arising from the study and suggesting some implications of the findings for practitioners, managers and policy makers and for future research.

The findings of the study highlight the complexities of bringing up children in contemporary times. Rapid social change has resulted in diversification in the roles of parents and extended family and different attitudes to children, particularly in relation to discipline. Health visiting practice shows evidence of evolving to meet these new family structures and functioning.

8.2 Limitations of the study

It is inevitable that the relevance of a study is restricted in some ways and important to identify and reflect on the limitations. —

Lack of involvement of other stakeholders as participants

The study set out to analyse parenthood and the role of the health visiting service from the perspectives of parents of young children, and it is acknowledged that the

views of others, such as health visitors themselves would contribute to the study. However, the literature review revealed a paucity of research which addressed the study aims of contextualising parents' views of health visitors within the reality of parenthood. It was therefore decided to concentrate on parents' perspectives only rather than involving other groups of participants.

Developments in health visiting since data collection and analysis

At the time the data collection was undertaken, skill mix was being introduced on a very limited basis within the area where the study was conducted, and therefore the study participants had only had contact with health visitors and not with other grades of staff such as nursery nurses or support workers. The results of the study therefore cannot be used to inform decisions about the introduction of skill-mix more widely, nor to address questions about the relative effectiveness of grades of staff other than health visitors in providing a service to parents. Also, community development is currently being adopted in the study area as a mainstream approach to health visiting and the possible involvement of parents providing support and advice to one another will offer another alternative and may change the role of the health visitor as perceived by parents. In response to recent policy changes outlined in Nursing for Health (Scottish Executive 2001) many changes to health visiting practice are anticipated to take on a wider public health role. It is therefore acknowledged that research can only reflect what is going on at the time of data collection and the findings and recommendations may need to be re-interpreted in the light of these changes in practice.

Transferability

Because of the small sample size it is necessary to interpret the findings of the study with some degree of circumspection. However, the study set out to use qualitative methods to gain an in-depth understanding of the issues being explored for which a larger sample would be inappropriate. Also, it is suggested that the 'typical' family is impossible to define. In addition, the interviews with individual families involved only parents of first-born children who did not have special needs and who were not on the child protection register. Parents of more than one child and families who are

considered to require more than routine health visiting may have different perceptions of parenthood and of the health visiting service. However, recruitment for the focus groups was done informally through playgroups and so some participants had younger and/or older children as well as the child attending the playgroup and it was not known if the children concerned were registered as being at risk of abuse or neglect or had special needs. The focus groups proved to be a source of rich data, and facilitated the involvement of parents who might have been inhibited by a one-to-one interview and this was felt to compensate for the lack of prior specific knowledge about the participating parents. The role of helping agencies with families deemed as needy, such as those with children with special needs or whose parents are recognised as having poor parenting skills, has been more fully explored in the past and is generally recognised as being necessary and beneficial, while there has been little work done to understand parenthood in relation to families without obvious difficulties.

As far as possible, participants represented the demographic profile of the study area. There was only one family from an ethnic minority, which would be expected from the very small number of ethnic minority families living within the area where the study took place.

Analysis of the data has provided an insight into parenting of young children and the role of the health visitor in working with families. Interpretation of the findings of the study using the theories outlined below increases the transferability of the research. This framework could be used more generally, for example to explore the health visiting process with other client groups such as the elderly and to examine the role of other agencies with families.

As discussed earlier (see Chapter 4.5 p102), the parents who participated in the study may have been influenced by the knowledge that the researcher is a health visitor. Parents may have emphasised the importance of their role as parents more to an interviewer with this background than to an interviewer seen as more neutral. They may also have presented their views of health visitors differently.

8. 3 The interpretation of the findings using the conceptual framework

The conceptual framework has been described in the previous chapter. Elkan (2000) calls for health visitors to explain their practice in terms of theory in order that evaluation can be carried out with reference to the theories which underpin practice, and the study provides this theoretical understanding of health visitors' work with families with young children. The interpretation of the findings are now presented in terms of the individual theoretical approaches before proceeding to a discussion of the interpretation using the conceptual approach.

Lazarus and Folkman's Theory of Stress and Coping (1984)

Lazarus and Folkman's theory of stress and coping (summarised in Table 1, p227) proved beneficial in interpreting the ways in which parents cope with the demands of parenthood, as it acknowledges both the positive and negative aspects of childrearing.

In terms of primary appraisal (described in Chapter 7.2 p236), parents appeared to perceive their role as a combination of benign/ positive, loss, threat and challenge, as proposed by Lazarus and Folkman (1984), with the exception of irrelevance which was noticeably absent. While parents saw their role as being benign/ positive because of the sense of meaning in their lives provided by children, they also experienced feelings of loss (of identity, freedom and financial well-being), threat (to relationships and career prospects) and stress (from tiredness and anxiety). For most parents childrearing was appraised as a challenge, with the potential for gaining from the experience in terms of fulfilment of an important and exciting task, but requiring the development of new strategies to cope.

Parents appeared to go through the process of secondary appraisal (described in Chapter 7.2 p238), collating advice from family, friends and health visitors in the light of their own unique understanding of their child and then deciding on appropriate tactics to apply to situations. This process was illustrated by one mother

in her reflection of how she filtered advice from various sources to address issues relating to her own children (see Chapter 5.18 p195).

Lazarus and Folkman (1984) propose that the more committed people are to something the more vulnerable they are to stress. The findings, by showing the sense of commitment and responsibility parents feel for their children and to society, support other evidence from the findings suggesting that parenthood is a stressful experience for most parents. This is illustrated by the assertion by one mother that before having a family she and her husband decided to put their children's needs before their own (see Chapter 5.6 p129).

Parents who participated in the study demonstrated their use of problem-focused coping (described in Chapter 7.2 p239). They defined problems they were experiencing with parenting, in relation both to their children's health and behaviour and to the difficulties they experienced in their capacity as parents. They then demonstrated their efforts to resolve problems in the ways defined by Lazarus and Folkman. Parents demonstrated the ways in which they attempted to reduce pressures: some mothers changed from working full-time to part-time, while one mother dealt with the stress of isolation by taking a part-time job which involved contact with the public (see Chapter 5.9 p151). Developing new skills and behaviours was important for many parents because of their lack of previous childcare experience. The ability to solve problems improved with practice, increasing confidence and a better knowledge of individual children. They also changed their aspirations as they came to understand that many so-called problems were an intrinsic part of childrearing and that other parents had more problems than themselves. In terms of Lazarus and Folkman's theory, parents demonstrated an acceptance of their responsibilities as parents, and showed an ability to solve problems in adjusting to their role; this was illustrated by the assumption of an organising role by one mother in her social activities as a full-time mother which helped to compensate for this aspect of her previous job as a teacher which she had enjoyed and missed when she was no longer working (see Chapter 5.9 p154).

Emotion-focused coping strategies (described in Chapter 7.2, p239) complemented problem-solving approaches to dealing with the stresses of parenthood. Difficult situations were reappraised, for example by deciding that “I just had to get on” with being a mother, as there was no alternative (see Chapter 5.3 p119). Many parents emphasised the positive aspects of bringing up children such as their awareness of having a unique place in their children’s lives and the pleasure of seeing children reaching important milestones. These features, which appeared to give parents a great sense of meaning, seemed to make worthwhile the day-to-day tedium which many parents described. Parents also sometimes coped by distancing themselves from situations and “letting things wash over me” (see Chapter 5.14 p177). Mothers who worked also distanced themselves from the stresses of parenthood, by compartmentalising the different aspects of their lives, as illustrated by one mother’s assertion that she needed to “switch off, on both sides” (see Chapter 5.9 p149).

Social support appeared to be the main source of help with coping, providing the means of reappraising situations in the light of other parents’ experiences and also being a source of information and support to allow parents to define problems and formulate solutions. Thus situations initially seen as problems could be redefined as ‘just phases’ that all children go through, (see Chapter 5.15 p187) and family and friends were used as sources of information on which to base decisions about approaches to dealing with children’s problems (see Chapter 5.15). Parenting did not present opportunities to use avoidance as a strategy for coping with stress because of the sense of responsibility they felt for children.

Parents demonstrated their increasing expertise in differentiating between situations which were amenable to change and those where coping depended on using emotion-based strategies. As parents gained experience in their role, they became increasingly realistic in their primary and secondary appraisals of situations, and more sensitive to the options for dealing with them, both in relation to problem-based and emotion-based coping strategies. By re-appraising situations in the light of new understanding, parents could realise that an emotion-focused approach would be more effective in coping with the situation; they could then concentrate their

problem-focused coping on changing their levels of aspiration and perhaps altering the environment to diminish their stress rather than trying to define and actively resolve the behaviour which would resolve spontaneously.

Data analysis suggests that the resources defined within Lazarus and Folkman's (1984) theory (described in Chapter 7.2 p239), including health and energy, positive beliefs, problem-solving skills, social skills, social support and material resources, apply very aptly to parenthood. Health and energy were shown to be important factors in parents' ability to cope, with the tiredness of the early days and mothers' physical problems post-natally diminishing their capacity to cope. Parents also indicated that their coping skills were enhanced by positive beliefs, illustrated by the apparent importance of approval of their parenting skills by grandparents (see Chapter 5.11 p164) and by the support of friends when encountering difficulties with their children (see Chapter 5.18 p195). The findings also suggest that parents' ability to cope increased as they gained skills in problem-solving (see Chapter 5.18). The theory's tenet that social support contributes to coping ability is also substantiated by the findings of the study; parents who were socially isolated seemed to be more stressed than those who were supported by family and friends. This was vividly demonstrated by one mother's depiction of herself as being alone with her baby, whom she was terrified might die, and then becoming more relaxed through attending a post-natal support group and reappraising the situation as being potentially enjoyable rather than frightening (see Chapter 5.12 p171). For parents with little established social support, having appropriate social skills was important in order to create new social networks. For example, the mother who had worked as a community education worker and therefore could be expected to find joining group activities relatively easy, appeared to be able to build relationships with others easily (see Chapter 5.12 p172), while others found it difficult to establish new social networks. The mother who had tried unsuccessfully to make new friends because of having no family around (see Chapter 5.12 p173), appeared to be very stressed, although she found her son easy to deal with. This mother had grown up surrounded by a large family in a rural area of England and may therefore not have had the social skills appropriate for establishing a social network in a Scottish city, and had referred

to her inability to adapt to the culture of a large office after being accustomed to the camaraderie of a factory. Positive beliefs were shown to be important in helping parents to cope, with the acknowledgement by one mother of her self-confidence supporting her perceived ability to resolve problems herself, with little need of help from other formal and informal sources (see Chapter 6.4 p199).

Parents' coping options were shown to be constrained by both personal and environmental factors (described in Chapter 7.2 p240). The most obvious was the lack of social support from families and close friends, often due to geographical remoteness, resulting, in the case of one family, in "international relationships" (see Chapter 5.11 p159), or because grandparents were engaged in paid employment or other interests. Many parents appeared reluctant to share the care and responsibility of children with others because they saw childrearing as solely their responsibility, or because they believed that grandparents were not able to care for children, exemplified by one couple's description of the maternal grandmother's inability to care for their son adequately for even a short time (see Chapter 5.11 p 162).

In terms of outcomes (described in Chapter 7.2, p240), parents' somatic health, morale and life satisfaction appear to be clearly affected by the balance between the stress they experience and their internal and external coping strategies. This can be illustrated by the contrasting experiences of two mothers. One mother (Int.11) described having considerable stress and also appeared to be depressed with low morale and dissatisfaction with life. The other mother (Int.6) appeared to have less stress and more coping resources; she was working part-time, with a good supportive network of family, old friends and friendships made with other mothers since the birth of her child. Lazarus and Folkman (1984) propose that morale is enhanced when reality matches expectations; the inexperience and unreal expectations of many parents who took part in this study suggests that contemporary parents are likely to experience low morale, which is borne out by the difficulties described by many parents, especially in the early days.

In relation to morale and life satisfaction, which Lazarus and Folkman (1984) associate with the relationship between expectations and outcomes, parents in the

study appeared to use their contact with other parents of children at the same stage as their own to work out their expectations and to realise that they were doing as well as others in the same situation. They could “pull each other up” (see Chapter 5 p170) thereby enhancing parents’ sense of well-being during a difficult phase.

Lazarus and Folkman (1984) suggest that the social environment can create stress in the form of social demands resulting in conflict, ambiguity and overload (described in Chapter 7.2 p231). Overload is caused by too many roles being expected of one individual. The dilemma over discipline described by many parents demonstrates conflict and ambiguity; parents felt that they had to react to their children’s misdemeanours but could not use physical punishment. This was demonstrated by one mother’s confusion about society’s apparent disapproval of physical punishment of children while blaming parents for the general decline in children’s behaviour (see Chapter 5.7 p133). Families where both parents were working full-time showed some evidence of overload, trying to balance the demands of parenthood and employment.

Bandura’s (1977, 1986) Social Cognitive Theory

Analysis of the data suggests that learning to be a parent involves three different strands: childcare skills, parent survival skills and creating a philosophy for family life. Bandura’s (1977, 1986) social learning theory provides a useful framework to discuss the ways in which parents acquire this expertise. Modelling (observational learning) (described in Chapter 7.3 p244) the behaviour of parents with older children allowed parents to use their assessment of the perceived outcome of childrearing strategies in deciding on approaches which they wanted to adopt with their own children. This was clearly demonstrated by one mother’s conscious effort to replicate the parenting behaviour of friends whose children and general family lifestyle she admired (see Chapter 5.15 pp187-188). Parents also modelled their behaviour on other parents at the same stage as themselves according to the short-term outcomes of parenting practices. Modelling was used less self-consciously by those who had previous experience of children, and who had grown up surrounded by younger children and observed how members of their extended family dealt with parenting issues. Some mothers who had fairly traditional roles could use their own

mothers as models; this was exemplified by the acknowledgement by one mother who did not work that she used her own mother as a role model because she felt that her lifestyle was very similar to that of her mother's at this stage of her life (see Chapter 5.6 p128). For fathers, however, this is more difficult, as contemporary fathers are expected to be far more involved with their children than in previous generations.

Enactive learning (described in Chapter 7.3, p245) was used extensively by parents, partly because of their limited experience of children prior to having their own, and in some cases limited contact with other parents, and also because of the emphasis most parents ascribed to the uniqueness of the individual child and the need for a personalised approach to dealing with the child based on what had been found to work for that child. However Bandura's proposal that enactive learning is likely to result in parents settling for an adequate rather than optimum approach to childcare issues suggests that enactive learning may restrict the development of parenting skills and also implies that second and subsequent children may be subjected to an approach which was tailored to their older sibling(s) but not to themselves. Health visitors and parenting education may provide a forum for parents to explore approaches which they would not easily discover using enactive learning. Enactive learning is also limited because of its reliance on short-term outcomes as evidence of effectiveness whereas modelling allows for long-term consequences of parenting practices to be assessed. One example would be the management of oppositional behaviour where physical punishment might prevent the child from persisting with unacceptable behaviour but might be a factor in the development of aggression later on.

Bandura's theory on the relationship between self-efficacy and mastery experiences, modelling, social persuasion and judgement of bodily states (described in Chapter 7.3 p246) is also borne out by the findings of the study. The findings suggest that parents' self-efficacy is greatly enhanced by mastery experiences, both by solving day-to-day problems and also from the positive feedback gained by seeing their children grow and develop. Parents' self-efficacy was also enhanced by successfully coping with the challenges they met and by recognising their personal resources.

Parents' self-efficacy also developed through modelling; by comparing themselves with others they sometimes decided that they were coping or performing better than others, thereby increasing their sense of competence.

The findings suggest that social persuasion, in the form of support of family and friends, also makes an important contribution to increasing parents' self-efficacy. Parents benefit by social persuasion per se and by increasing parents' chances of executing mastery experiences, which in turn further enhances parents' self-efficacy. The acknowledgement by one mother of the importance of support from friends and family when she and her husband were trying to find solutions to her son's difficulties in interacting with other children, in the belief that they were the only ones who could resolve the issues (see Chapter 5.18 p196), highlights the role of social persuasion in maintaining and increasing self-efficacy. Similarly, grandparents who were not actively sharing in the care of children or offering advice could still help parents to carry out their role by giving them approval from a respected source and thereby increase their self-efficacy. The somewhat ambiguous comment of one father that his mother gave him "a lot of help" followed by a description of how she told him to "get on with it" (see Chapter 5.11 p66) suggests that the help to which he alludes is an increase in his self-efficacy rather than any practical assistance in sharing his parenting responsibilities. Similarly, attending the clinic to check "that what I was doing was OK" (see Chapter 6.8 p213) suggests that reassurance from the health visitor increased this mother's self-efficacy. Bandura's proposal that stress predisposes individuals to failure is demonstrated by the feelings of vulnerability expressed by one mother when she was depressed and worried that her children might be taken into care (see Chapter 6.10 p226), and by another mother's anxiety about having her children removed after her baby had had an accident for which she felt responsible (Chapter 6.10 p226). The latter mother's reflection about the health visitor being able to understand her feelings implies that the health visitor saw her role as being to provide support to a mother whose self-efficacy had been diminished, and who could best be helped by boosting her confidence rather than by more practical measures.

Bandura (1986) proposes an inverse relationship between self-efficacy and stress (see Chapter 7.4 p247); this was illustrated by the mother who believed she was generally self-confident and also appeared to find caring for her daughter relatively easy (Int. 4).

In terms of health visiting practice, the study findings suggest that parents need a variety of approaches which can be explained in terms of Bandura's (1977, 1986) theory of social learning. Sensitivity is required to tailor interventions to suit the needs of individual parents, and to balance the provision of direct advice and information with indirect approaches such as reassurance and other strategies which increase parents' self-efficacy such social persuasion.

Family nursing

Family nursing theory (described in Chapter 7.4) provides a useful framework to interpret the findings both about family life and also about the role of the health visiting service in working with families with young children. The interpretation of parents' experience is facilitated by examining the family unit, the relationships within the unit, and the relationship of family members with their wider social network. Parents' sense of being solely responsible for their children's upbringing in relation to their health, welfare and discipline suggests that in many cases the family unit was relatively closed; this sense of the family being a fairly closed system was also shown by the lack of involvement shown by many grandparents in the rearing of children, illustrated by one couple's (Int.12) comment that the mother's parents "really just visit, and don't know Toby that well" (see Chapter 5.11 p164). In contrast, one maternal grandmother (Int.1) was very involved in her child's upbringing and was much more part of her family system than was the case for many families (see Chapter 5.11 p160). One family (Int.5), who had no grandparents still alive, appeared to have a fairly closed family system, with the mother's sister and her family being closely associated with them to the exclusion of others. Another couple (Int.18), with no close family and friends nearby, were trying to establish a new social network to compensate. This mother's reflections about having many acquaintances (see Chapter 5.12 p171) but few strong social supports suggests that

this family could be depicted in an ecomap with a large volume of social contacts at a distance from them but little support closely associated with the family. The birth of a first-born child inevitably involved change for parents, there being no possibility of reverting to former roles and attitudes. The findings provided examples of different outcomes of this morphogenesis, as defined in relation to family nursing (described in Chapter 7.4 pp249-250). The reflections by one mother on how she should have perhaps involved her partner more in the early days, suggested that this couple's transition to parenthood had resulted in maladaptation, with a lack of involvement by her partner and obvious tensions between them. In families where the father was working long hours (see Chapter 5.8 pp141-142), the transition to family life seemed less successful than when fathers were able to spend more time with their partner and child, as illustrated by the father whose job as a teacher with long holidays and relatively short working hours allowed him to be very involved with family life (see Chapter 5.8 p142).

Family nursing also provides a useful framework for the interpretation of parents' perceptions of the role of the health visitor. Both those with and those without good support from family and friends recognised the way in which health visitors could to some degree compensate for lack of support from parents' family systems. Thus the health visitor can play a greater or lesser part in the family system, depending on circumstances such as the availability of traditional supports and the needs of individual families. It might be expected that of families with similar social networks those who are experiencing parenting difficulties would have more involvement with their health visitor than parents who were not encountering problems with caring for their children.

For the parents who believed that health visitors are focused on the early days of parenthood, the health visitor would be placed at a greater distance from the family system after this initial period than would be the case for parents who believed the health visitor to have a wider remit. For parents such as those described above where there was a very close relationship between the family and the mother's sister's family (Int.5), the health visitor would be placed fairly distant to the family (see

Figure 3: Ecomap for Susan and George (Int.5)

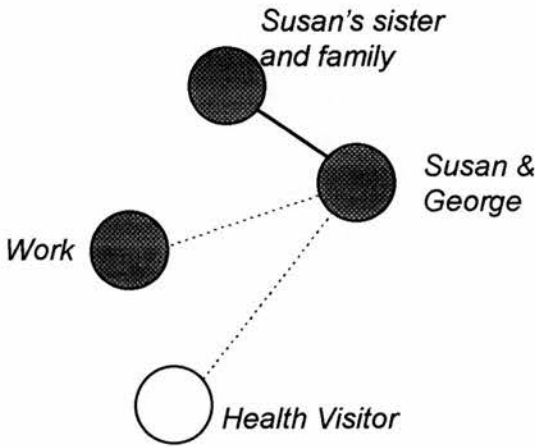


Figure 4: Ecomap for Carol and Kevin (Int. 11)

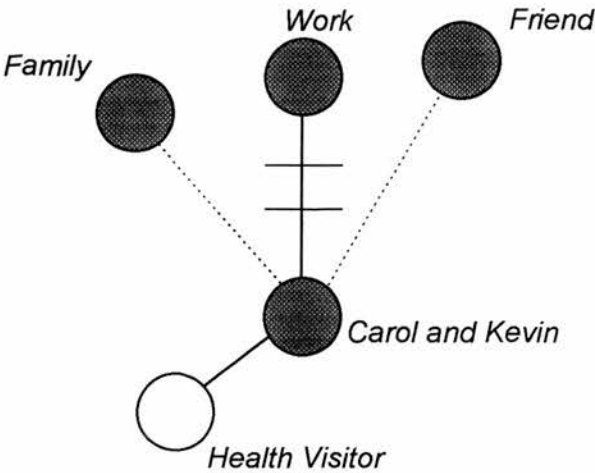


Figure 3, p269). In this situation the health visitor did not really have a significant role because the mother's family provided all the support and advice she needed because of the close relationship they had and because they had a child who was just a little older than their son. On the other hand, for the family who was very socially isolated (Int.11), the health visitor, who was substituting for many of the roles which her family would have played if they had been closer and were providing for her sister who lived near the large extended family, would be placed very close to the family unit (see Figure 4, p269). When working with individual families, therefore, it might be useful for health visitors to think in terms of family nursing, and to include this approach, as well as other indicators of vulnerability, in assessing the needs both of individual families and of their caseloads. This could be used to describe and quantify the increased involvement that health visitors have with families who are considered vulnerable by health visitors, but who do not meet health Trusts' criteria of vulnerability, usually confined to risk of child abuse (see Chapter 3.8 p81). Thus family nursing could be used to demonstrate the need for health visitors to provide support to middle-class families who are isolated from extended families because of geographical distance whose needs are not usually highlighted by indicators relating to child protection.

Twinn (1993) advocates starting from the perspectives of parents and working in partnership with them. Drawing on Whyte's (1997) principles of family nursing, working in partnership with families to help them to identify their own strengths and weaknesses would be expected to result in families learning to make sense of their own family situation in a way that might promote the utilisation of their own resources to create an optimum environment for children and their parents. Family nursing provides a useful framework for discussing the role of the health visiting service in providing support to families and in discussing the caring aspects of interventions, thus explaining the importance of "fringe activities" (de la Cuesta 1993) (as discussed in Chapter 3.7 p79), to managers and policy makers. Activities such as running post-natal support groups can also be justified in terms of family nursing as providing parents with informal and mutual support allows the health

visitor to assume a less involved role with families once other social networks are established to compensate for lack of extended family and established friendships.

In working with families the assessment of family relations in terms of cohesion, adaptability and communication, as described by Olson's Circumplex Model, (described in Chapter 7.4 p250), provides a useful means of planning and carrying out interventions with parents who are experiencing relationship difficulties. Where parents are disengaged, perhaps due to the pre-occupation of the mother with a child and overinvolvement of a maternal grandmother, or enmeshed, with no sense of individual identity, the model may help health visitors and parents to identify problems and possible changes which could be made to promote good family dynamics. The depiction by one study participant of a family she knew whose dynamics she admired and emulated (see Chapter 5.15 pp187-188), suggests that they had a flexible approach, connected relationships and good communication. In view of the evidence from the literature of the importance of fathers being involved from the beginning, illustrated in this study by one mother's feelings that her husband's lack of involvement in the early days was probably responsible for his present remoteness (see Chapter 5.8 p141), it seems that health visitors are well placed to detect early signs of problems. Thinking in terms of families' adaptability may also enable health visitors to help families experiencing difficulties with parenting or with relationships between family members or with others to identify themselves as being rigid or chaotic and to work out ways of improving the family's ability to adapt to new situations. Helping parents to be aware of the importance of good communication is also shown to play a part in facilitating good family functioning. Health visitors and midwives are also in a good position to carry out preventive work with parents ante-natally and post-natally, both in groups and on a one-to-one basis to help parents to work out ways of establishing good family dynamics by recognising family strengths and by identifying and addressing problems at an early stage. These early days provide an opportunity for the dynamics of the newly formed family to get off to a good start when the child's contribution, although significant, is still indirect.

Luker and Chalmers (1990) suggest that the ease with which health visitors can engage with clients depends on the degree to which individual families are receptive to outside influences (see Chapter 3.7 pp73-74). Findings from this study suggest that family nursing concepts would help health visitors to understand how individual families function when offering a service to them and to tailor interventions to suit the dynamics of individual families. Where families are too open, in Minuchin's (1974) terms (see Chap 7.4 p239), it may be important to help parents to learn to use their own resources more than in they have done in the past, and in families where boundaries are closed it may be necessary to respect families' wishes for privacy while demonstrating the value of the service on the parents' terms, for example by maximising opportunities at routine clinic attendances. However, when there is concern about the welfare of children, it is acknowledged that a more intrusive approach is often required, and that in these situations health visitors may be guarded about discussing some issues because of concerns that access may be withdrawn or because the health visitor may compromise her personal safety by discussing these concerns openly with parents.

Discussion

The study findings have been interpreted in terms of the three theoretical approaches. Analysis of the data suggests that social support is an important common factor in interpreting the findings in relation to the three theories which provided the framework for the study.

Social support is important in enabling parents to cope with the stress which the findings suggest is experienced by many parents, providing a resource from which parents can learn appropriate skills and which can increase parents' self-efficacy; it is also important in relation to the family system and contributes to the determination of the role of the health visiting service in a family. When parents lack social support, they find bringing up children in isolation difficult, due to their reliance on enactive learning, and their lack of buffering from stress, and therefore are likely to rely more heavily on the health visiting service for advice and support. This interpretation supports the finding that parents regard the provision of support on a one-to-one

basis and facilitating parents' inclusion in a social network by running post-natal support groups to be a vital aspect of health visitors' work with families with young children. Social support acts as a buffer against stress for parents by helping them to realise the normality of their situation and diminishing the perceived difficulties of the attendant problems. Families' social networks provide emotional support, making parents feel cared for, practical support with childcare, information and advice and feedback to parents about their performance.

The importance of home visiting can also be explained from the perspectives of the theories utilised in the study. The home visit, by being less hurried than clinic contacts, and with the whole family centre-stage, allows the health visitor to assess the family situation. Home visiting provides the ideal forum for health visitors to gain an understanding of the dynamics of individual families and to build up the trusting relationship which appears to be the cornerstone of successful health visiting practice. By helping families to understand their family system in terms of cohesion, adaptability and communication, and the permeability of the family to outside influences, and gaining an insight into the family's stresses, coping resources and level of self-efficacy, health visiting interventions can be tailored to meet the needs of individual families. Families who are assessed as being balanced in their internal relationships, with good social support, high levels of self-efficacy and with low stress and good coping resources, can be offered minimal health visiting interventions. As well as preserving health visiting resources, this prevents intrusion into the lives of families who may rightly see no role for the health visiting service beyond routine child health surveillance. On the other hand, families who are assessed as being vulnerable in terms of the theories discussed, can be offered support and help to change both internal and external factors to improve family functioning.

Taking account of families' resources as well as stresses, as proposed by Lazarus and Folkman (1984), is also an important factor in the assessment process, which is likely to be most accurate when carried out in partnership with families. Vulnerability assessed in these terms may be a more accurate indication of the need for health

visiting interventions than when vulnerability is appraised by the 'official' guidelines and checklists referred to by Appleton (1995) (see Chap 3.8 pp81-82). This is relevant both in families where child protection is an issue and also in families where there is little risk of child abuse but where difficulties in family functioning are likely to lead to other deleterious outcomes for children, such as parental separation, mental health problems in parents and behavioural problems in children. Some families where the parents are both working full-time may be deemed as being vulnerable when assessed in the terms presented by the theories discussed, because of stress, fatigue and lack of social support, although child abuse would not be considered to be a likely sequel.

Bowns et al. (2000) in a survey of 403 'low-risk' mothers of babies aged 9-12 months to assess their levels of satisfaction with the health visiting service, found that the number of contacts between mothers and health visitors was much higher than would have been expected for this group. The average number of 10 contacts regarding children's health comprised five formal contacts related to child health surveillance with the other five being demand-led. This finding supports the proposal that a holistic assessment of vulnerability, based on the conceptual framework used in the present study to take account of sources of parents' stress and supports, would more accurately assess families in terms of their requirements for support and advice. Also, innovative ways of providing help to parents, for example using community development approaches or structured parenting programmes, need to be developed and evaluated to assess whether they are in fact address parents' needs more sensitively than the one-to-one parent-initiated contacts with health visitors.

This more holistic assessment of vulnerability could also be used to work with families to assess their own strengths and weaknesses and help them to identify strategies to promote good family dynamics which will provide their children with an optimal childhood experience, which seems to be important for most parents (see Chapter 5.2 and 5.6). The legitimacy of the "fringe activities" (de la Cuesta 1993) of health visiting is also demonstrated when discussed in terms of the theoretical framework of the study.

CHAPTER 9: CONCLUSIONS

9.1 Introduction

The previous chapter provided a discussion of the findings using the conceptual framework outlined in Chapter 7, taking into consideration the limitations of the study. This, the final chapter of the thesis, is devoted to a reflection on the contribution which the study has made to knowledge and practice, before discussing issues highlighted by the study and the implications of the findings for relevant professional groups.

9.2 Contribution of the study to knowledge and practice

The study provides an insight into parents' perceptions of contemporary parenthood and health visiting practice. It demonstrates parents' understanding of their role and of the health visiting service. The study contributes to the knowledge base on which to develop evidence-based health visiting practice, which is high on the political agenda (Scottish Office 1999a). Rolfe (1998) calls for the use of theory in making nursing research more generalisable (transferable) and more applicable to nursing practice. The use of a conceptual framework based on three theoretical approaches enhances the transferability of the interpretation of the findings to other research topics related to stress and coping, education and family life and allows the research to complement other research areas currently being addressed in health visiting, such as vulnerability. Discussion of the findings in terms of family nursing is important in light of the introduction of the family health nurse, as proposed by the WHO public health document (1998), and currently being piloted in Scotland. In view of the current political interest in parenting education (Home Office 1998) and the increasing involvement of health visitors in this area as a result of this, it appears timely to use the present study to provide a greater understanding of the processes involved in learning parenting skills; Bandura's social learning theory provides the ideal framework for this. The use of Lazarus and Folkman's (1984) theory of stress

and coping provides evidence to practitioners, managers and policy makers of the importance of providing support to parents.

By explaining health visiting practice in terms of the theoretical approaches used in the study, the aims and processes of health visiting interventions are more easily articulated. Development of the health visiting service may also be facilitated by considering parenthood and health visiting practice in terms of the conceptual framework.

9.3 Issues arising from the study

Parents' unique understanding of their children

Parents seem to believe that they have a unique understanding of their child, part of which they attribute to their ability to identify and understand traits in their child which they believe are inherited. Parents who are bringing up children not biologically related to them, in reorganised and adoptive families or when children are conceived artificially with donor sperm or eggs, may lack this sensitivity to their children's personalities. Those playing the part of grandparents to these children would also lack this insight into children's genetically determined characteristics. However, other factors, such as spending time together with children and learning how they react to different situations (see Chapter 5.17) also contribute to parents' understanding of their children and may be more influential in families where the children are not genetically related to parents.

Discipline

In eight European countries there are explicit bans on physical punishment by parents and all other carers (Department of Health 2000). While physical punishment by parents is still legal in England and Scotland, consultation documents have been produced in both Scotland and England to look at possible changes in legislation to prohibit physical punishment by carers other than parents, and to look at ways of supporting parents to use other means of controlling their children (Department of Health 2000, Scottish Executive 2000b). Some agencies such as Save the Children have called for a complete ban on smacking, linking Sweden's improvement in

juvenile delinquency, drug use and children taken into care with the ban on smacking introduced in 1979 (Durrant 1997). There is therefore a political move to reduce and perhaps eventually ban the use of physical punishment as a means of disciplining children.

According to parents' accounts, they want to produce children who are well-behaved without the use of harsh punishment. The management of young children's behaviour presents challenges and dilemmas for parents. While there is much literature to suggest that physical punishment is harmful and certainly does no good, the data in this study give the impression that smacking is a normal part of childrearing for many parents, as was found by Graziano (1994). This applied even to those said that they believe physical punishment to be morally wrong or ineffective. However, it raises the question of whether an activity being commonplace legitimises the activity. Many parents appeared uneasy about using physical punishment and appeared to regret incidents when they had resorted to smacking their children.

It may be feasible to minimise parents' use of physical punishment at the pre-school stage by teaching them about the limited understanding young children have of verbal reasoning (Blum 1995) and also by promoting the use of appropriate techniques such as 'time out.' Positive parenting may also be promoted by helping parents to understand the benefits of managing their children's behaviour according to the developmental stage they have reached throughout childhood and adolescence.

Fathers

The early involvement of fathers in childcare appears to be important in establishing their role in family life, but is often hampered by the separation of fathers from mothers and babies while in hospital during the immediate post-natal period.

However, as it becomes increasingly common for mothers to be discharged from hospital just hours after delivery, it could be expected that in uncomplicated cases the mother will have less of a 'headstart' than did the participants in this study. The provision of family rooms in situations where the condition of the mother or baby requires a longer stay in hospital might help to promote the father's involvement in family life at this early stage of the transition to parenthood. Encouraging fathers to

spend time with their baby in the early days of coming home from hospital may help fathers to bond with their child and promote good family dynamics. Making the couple the focus of ante-natal care and education might lessen the difference in confidence and knowledge between parents.

There is an implication from the findings that fathers play a particularly important role in their sons' upbringing, especially in relation to discipline. This has relevance when considering single parent families, especially in relation to mothers and sons.

As found in previous studies, egalitarian parenting appears still to be an ideology rather than a reality in most families. However, it might be expected that the trend towards more equal sharing of parental responsibilities will continue, and family nursing provides a useful framework to encourage fathers to be more involved in caring for children.

Health visiting

The health visitor was portrayed by many parents as a source of practical advice and reassurance, providing the guidance which might in the past have been given by grandparents, with health visitors seen as having more recent and extensive experience of children than seemed to be the case for the grandparents discussed in the present study.

Many study participants believed that personal experience of childrearing was useful for health visiting practice. Assuming that clients of many other areas of the health service do not expect those providing them with support and advice to have had relevant personal experience, for example in most hospital specialities, it is interesting to speculate on the reasons behind this sentiment. The sentiments expressed may be due to the fact that bringing up children is considered a normal part of life which in the past was seen as being part of the private sphere of the family, with advice being based on experiential knowledge rather than on theories of psychology and child development; they may also be related to the feelings of many parents that having a child completely changed their own ideas and values (see Chapter 6.10). This view of parents may represent an 'image problem' for health visitors in terms of parents' understanding of their roles and training. A literature

search did not uncover any research carried out into personal experience of nurses' professional practice areas.

Parents' views of the parent-health visitor relationship emphasises the way in which health visiting bridges the lay-professional spheres, and the informal setting of health visitor interactions, at home with young children who have no sense of formality.

The differentiation between 'official duties' and 'fringe activities' is demonstrated when parents appear to interpret "blethering" (see Chapter 6.8 p216) as fringe activities, extra to the official agenda of the health visitor, but which health visitors classify as providing emotional support or mental health promotion. This finding illustrates Dingwall's (1977) suggestion that observing the conventions of normal conversation means that "what happens on a visit may look like a chat" (p30). However, in order to explain health visiting practice it is important that the underlying processes are described in terms of theories which underpin the interpretation of these processes.

Buckingham (1999) reviews the role of the formal written agreement between the health visiting service and client in making the process of health visiting quite transparent to all parties, including managers. She proposes that an informal contract promotes a partnership model of working with clients and is an appropriate complement to the packages of care now being used to measure health visiting interventions in many Trusts. The agreement form is likely to clarify the role of the health visitor to clients and also to commissioners of the service; it sets out reasons for the health visitor's involvement and also the course of action being undertaken. Buckingham (1999) suggests that this proposal would resolve the problem of exposing the work of the health visitor. The conceptual framework used in the present study might be a useful base on which to develop nursing contracts and packages of care for parents relating to supporting parents, helping them to develop their parenting skills and promoting effective family functioning.

Parents in the study described ways in which health visitors helped them by providing emotional support to them. Cody (1999) suggests that although offering clients support for psychological health needs is a common health visiting

intervention, it is not generally accepted by managers and policy makers as legitimate health visiting practice. She puts forward two questions: whether health visitors do in fact provide a therapeutic service, and if so, why it is not recognised. She goes on to propose that health visiting is fundamentally therapeutic, but without the specific underpinning of theoretical discipline, which is assumed to be associated with most therapy and counselling. Cody highlights the evidence in many health visiting studies of health visitors' "tacit knowing about people and being able to develop empathic responses to people's problems" (p121). Cody calls for more evidence to be sought of the effectiveness of psychological support provided to clients by health visitors. The present study contributes to the theoretical understanding of the psychological support provided by health visitors to parents of young children.

9.4 Implications of study

The study clearly demonstrates the need for support for families with young children, and suggests that health visitors generally display sensitivity in assessing and responding to families' needs. There are indications that family nursing may provide a useful framework for the development and practice of health visiting. This approach has the potential to promote effective family functioning and thereby foster children's physical, emotional and social development. The use of Lazarus and Folkman's (1984) theory of stress and coping and Bandura's (1977, 1986) theory of social learning would also appear to facilitate the planning and delivery of health visiting interventions, by providing a framework for planning and evaluating health visiting interventions aimed at helping parents to cope with the stresses which appear to be associated with childrearing and to learn the skills required to bring up children.

Service providers

The study shows the value of the health visiting service in supporting parents in their role. The importance of the relationship between health visitors and clients, and also of the approach taken by health visitors in working with clients, demonstrates the sensitivity which health visitors require in order to achieve optimum outcomes from their interventions with parents. Health visitors show an awareness of individual

parents' circumstances, and need the freedom to be able to tailor the service to meet these needs. Health visitors appear to use a holistic approach to the assessment of vulnerability, identifying families requiring support who would be missed using only indicators relating to risk of potential child abuse or socio-economic measures. The theoretical framework used in the study may provide a useful means of explaining and justifying health visiting practice to managers and policy makers and enhance the understanding of health visitors' perceptions of vulnerability as already explored by Appleton (1994) and Williams (1995) (see Chapter 3.8 p80). Home visiting is an important aspect of health visiting and the study illustrates the difference between home visits and clinic attendances in the degree to which parents' needs are met, endorsing the recommendation of the Acheson report into health inequalities (Department of Health 1998). Health visitors must be commended on their tenacity in continuing to provide the service which parents clearly need and value, as demonstrated by the findings of this study, against a background of pressure to conform to an increasingly medical model of assessment and service delivery. This erosion of the principles of health visiting practice began with attachment to general practice, increased with the introduction of fund-holding by general practitioners and has continued with the advent of nurse prescribing and of the administration of immunisations by health visitors. The advent of Local Health Care Co-operatives (Scottish Office 1998), with the appointment of medical directors, is also likely to lead to an increasing emphasis on the medical model. However, the recent move to strengthen the role of public health to address health issues may reverse this trend and facilitate the adoption of a more holistic approach to primary health care. In particular the recent government document (Scottish Executive 2001), promoting the role of nurses, particularly health visitors and school nurses, in public health, provides an opportunity for health visitors to review their practice. This document proposes changes in health visiting practice supported by the findings of the study, such as the introduction of a family health plan to be used to work in partnership with families to set out goals and ways of achieving them.

Parents who took part in the study appeared to see the health visitor's primary role as providing support and advice, and made little reference to child health surveillance. They were also generally critical of clinics which were often described as rushed (see Chapter 6.10 p230). This criticism has been a recurring theme throughout health visiting research (Clark 1984; Knott and Latter 1999), and needs to be addressed. Child health clinics in their present format have been deemed to "consume significant resource and have little or no benefit" (Scottish Executive 2001 p44), and it is proposed in the same document to reduce routine screening and surveillance, which would represent a fundamental change in health visiting practice, allowing more time to be devoted to family-focused interventions.

While the study demonstrates the role of the health visiting service in meeting parents' needs, other professionals and lay sources of help may be as well or better placed to provide the support which parents appear to require. The needs of families highlighted by the present study may well be best met by working in partnership with other agencies such as education, social work and voluntary organisations to provide the support which many parents appear to require in order to successfully carry out their role. Skill mix may also offer opportunities to increase the support of families, for example by employing nursery nurses and others to offer support to families, especially where child protection is not an issue. The adoption of community development into health visiting practice, currently taking place in many areas including the Trust where the study was undertaken, also affords opportunities to look at effective ways of providing support and advice to families, and in particular focusing on the whole family as the unit of care. Community development will also lead to the health visiting service becoming more user-focused rather than professionally led.

Analysis of the data strongly supports the introduction of family nursing into health visiting practice. While the principles of health visiting (CETHV 1977) state that health visiting should involve health promotion at the individual, family and community level, until recently most health visiting practice in relation to families

with young children has been concerned mainly with mother and children. There are clear indications from the findings of this study that the family should be seen as the unit of care, particularly in light of the evidence from the literature and the study findings of the difficulties encountered by many fathers in adjusting to parenthood.

Health service managers

Elkan et al. (2000a) in discussing the findings of their systematic review of domiciliary health visiting, raises the issue of the way in which concerns which have been identified in health visiting research since the 1980's have not been addressed either by research or by policy action. They highlight in particular tensions between health visitors' reliance on parents' voluntary involvement with the service and managers' expectations of their role. The increasing medicalisation of health visiting is in contrast to the evidence that non-directive, supportive interventions, "treated by employers as non-work" (p229), are most effective. Thus more broadly based interventions in which the multiple needs of individuals and families are addressed are more effective than those restricted to the pursuit of a narrow range of outcomes. This supports the introduction of family nursing to health visiting practice and recognition of the usefulness of this holistic approach.

The study suggests that the role of the health visitor in working with parents of young children is as important today as it was in the past, although the emphasis may have changed; it also demonstrates the value of a needs-led service rather than one driven by organisational demands. Health visitors need freedom to use their professional judgement to assess the needs of their individual clients and caseloads, and to deliver a service appropriate to these needs. Outcomes defined in terms of quantifiable parameters, such as immunisation rates, clinic attendances and numbers of contacts, reflect the success of only a small part of health visitors' work with young families; this study teases apart other, equally important aspects of health visitors' work and shows their value to contemporary parents. However, managers will be required to be made aware of the evolving recognition of qualitative research as a valid means of assessing need and effectiveness before studies such as this are accepted as demonstrating evidence based practice. There is also a need to find

outcome measures which will give more quantifiable measures of effectiveness; these could involve the use of scales measuring aspects of family functioning such as parental self-efficacy which, as well as establishing the effectiveness of health visiting interventions, would also make explicit the aims of family nursing as applied to health visiting practice. The assessment of vulnerability in the ways discussed earlier is likely to provide more useful indicators of staffing needs. The introduction of contracts between health visitors and clients, as proposed by Buckingham (1999), would clarify health visiting interventions to both the client and to managers. Contracts would also expose “fringe activities” (de la Cuesta 1993) and force managers and policy makers to endorse or forbid them and thus clarify the role of the service to practitioners, parents and managers.

Educators

The study provides evidence to suggest that health visiting students may benefit from using the theoretical approaches used in this study to learn the skills required for working with young families and perhaps other client groups. The introduction of family nursing to the curriculum would enable the health visitors of the future to conceptualise families as the focus of their work rather than as being contextual to individuals or mother-child dyads. The concepts could also be used in post-basic education and continuing professional development to enhance professional practice. The study findings also suggest that more emphasis on user perspectives would be beneficial in education.

Policy Makers

The promotion of good parenting skills and the provision of support to families with young children is high on the political agenda as a means of improving children's health and intellectual development, promoting social inclusion and reducing inequalities (Department of Health 1998). The Sure Start Programme aims to provide support and better services for parents, strengthen marriage and provide help for families who are encountering problems. Positive parenting is also being promoted as a means of reducing juvenile delinquency and childhood mental health problems (Scottish Office 1999b).

Appleton and Clemerson (1999) highlight the need for the recognition of the work done by health visitors in intervening and working preventatively at an early stage with families who have problems which if not resolved are likely to progress to child protection issues. The importance of this type of short-term preventative work is emphasised in the report of the National Commission of Inquiry ('NSPCC 1996) into the prevention of child abuse. Appleton and Clemerson (1999) use as examples of common health visiting situations where families are under stress because of children's sleep problems, maternal depression and domestic abuse. While recognising that the health visiting caseloads do not permit long-term intensive interventions with families, health visitors are often able to prevent problems from developing into full-blown child protection cases, and can refer on and maintain contact with families if the problem cannot be resolved at this low-key level. The authors conclude that the term 'children in need,' which derives from the 1989 Children Act (Department of Health 1989), should be "a broad concept encompassing protecting children from disease, accidents in the home and on the roads, and from understimulation" (p136), and should encompass public health concepts by offering a universal service.

The study highlights the dynamic social context of parenting and also clarifies the kind of help which parents are seeking in developing their skills and which health visitors can and do provide. Current government interest in providing parent education would benefit from assessing the role the health visiting service can play. Health visitors have the advantage of already being familiar to families, and their involvement does not carry the stigma associated with other agencies. The study demonstrates the trusting relationship which most parents have with their health visitors which could be used to provide further interventions to promote optimal family functioning. Other members of the health visiting team, such as nursery nurses may also be able to provide effective support to families, and the use of skill mix requires development and evaluation.

The recent government document, *Nursing for Health* (Scottish Executive 2001), addresses many of the issues already discussed. As well as proposing the use of the

plan (see p281), consideration of appointing family health nurses, trained specifically to work with families, is also recommended once the current pilot scheme has been evaluated.

The current emphasis on addressing inequalities in health (Scottish Office 1997) involves targeting services at those with greatest health needs; the study results suggest that health visiting may be best retained as a universally available service aimed at preventing problems, promoting optimum conditions for children to grow and develop, and helping families to identify and address problems at an early stage. However, many families may need minimum health visiting contact and may be best served by leaving the onus for contact with the service on themselves in order to make best use of resources. Vulnerability measured in terms of the conceptual framework used in the study may also be more useful in assessing families with a view to targeting those who would benefit most from support from the health visiting service and other sources of help.

Future research and development

Community development and skill mix are currently being incorporated into health visiting practice, and there is also a move to an increased public health role for health visitors. Ways of providing support to parents will therefore need to be planned and evaluated using these new approaches. The role of the health visitor in promoting good family dynamics during the transition to parenthood and in identifying and addressing problems in family functioning at an early stage needs to be developed and appraised. Approaches to helping parents to understand and address issues associated with relationships within the family and with others needs to be developed. The study suggests that family nursing would be a good basis on which to develop health visiting practice, and the combination of family nursing and community development, with the enhanced use of skill mix where appropriate, may provide a means of addressing the needs of contemporary families. Guidelines need to be developed to assess vulnerability in terms of factors shown to be important in providing an optimal family environment for the nurture and development of children, such as the stresses which often appear to be present in dual-earner families.

Elkan et al.(2000a), in response to Luker's (1978) supposition that "subtle, intangible or elusive" changes are not worthwhile goals (see Chapter 1 p5), propose that interventions aimed at improving family functioning, such as raising maternal self-esteem and promoting good relationships between parents and children, are indeed valid but require more thoughtful approaches to outcome measurement than more tangible goals associated with outcomes such as immunisation rates.

Elkan et al. (2000a) also contend that health visitors, in common with other professionals such as doctors, "have an understanding, borne of experience, which can yield important insights of a kind which can never be generated through clinical trials alone" (p75). They also refute the idea that all interventions not proven as being effective should be deemed ineffective rather than seeking appropriate methods of evaluation. The present study, by interpreting the findings using the conceptual framework outlined in Chapter 7, makes the processes associated with parenthood and health visiting more transparent and amenable to identification of goals and possible evaluation strategies. Effective health visiting interventions have been devised to detect and provide support to women found to be suffering from post-natal depression (Holden et al. 1989). Heath visitors would be well placed to build on their skills to use a family nursing approach to offer interventions with families aimed at assessing and measuring other important factors which affect children's health and welfare.

Building on the findings of the present study, it would be useful to undertake quantitative studies to measure the effectiveness of health visiting interventions in terms of their effect on relevant parameters such as parental stress, self-efficacy and family functioning.

9.5 Conclusions

The study set out to explore parents' perspectives of parenthood and the health visiting service. The analysis and interpretation of the findings has provided an insight into the processes involved in childrearing and in health visiting interventions with parents of young children. Cowley (1996a) has identified how health visiting

practice has changed to meet changing health and social needs. The present study suggests that health visitors are well placed to facilitate the provision of the help and support needed and sought by many parents, but will have to evolve to meet the current public health agenda and emphasis on user-focused services.

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Appendix 1: Interview Guide

Parenthood

1. What do you enjoy about being a parent and what do you not enjoy/find difficult?
2. How does being a parent differ from what you expected before you had a child?
3. Can you tell me about the process of adapting to life as a parent?
4. What has helped/ would have helped in this process?
5. How does your experience of being a parent differ from your own experience of being parented, what do you want to be the same, what do you want to be different?
6. How confident do you feel about your ability as a parent?
7. Do you think that you are more strict/less strict than you should be?
8. What sources of advice do you use to learn about parenting / solve problems with your child?
9. What helps/ would help you to be a good parent?
10. What part do you each (parent) play in bringing up your child?

Health visiting

11. Has the Health Visiting Service helped you to acquire parenting skills?
If so, how?
12. Has the Health Visiting Service helped your confidence and your ability to make decisions about your child yourself?
13. How would you describe the health visitors you have encountered?
14. What role do you see Health Visiting as having?
15. Good aspects/ bad aspects/ things which could be improved in Health Visiting in relation to parenting skills.

Appendix 2: Focus group guide

QUESTIONS

1. **Icebreaker question.** What do you like and not like about being the parent of a young child ? (answered by researcher and each participant)
2. What it is like being the parent of a young child?
3. How do you think your own upbringing has affected the way you are bringing up your own children?
4. What sources of help do you find most useful in dealing with parenting?
5. How does/should the Health Visitor play a role in your lives?

Appendix 3: Information sheet for focus group participants

LEARNING TO BE A PARENT: DOES THE HEALTH VISITING SERVICE PLAY A PART?

What is the study about?

In order to assess the effectiveness of the health visiting service in Edinburgh, research is being carried out to look at how parents of young children learn about how to manage their child, about how confident they feel as parents, and about what role the health visitor plays in the process of learning to be a parent.

The study is being funded jointly by Edinburgh Healthcare Trust, which employs the health visitors working in Edinburgh, and the Scottish Office; it is being supervised by the Department of Nursing Studies at Edinburgh University.

What is the purpose of the Group Discussions?

The group discussions will provide information about issues of interest to parents in relation to childrearing, and will also help to develop a questionnaire which will be sent to 200 parents later in the study.

What will the results be used for?

The results will be used by the health visiting service in order to look at possible changes which would make the service better suited to parents of young children.

Appendix 4: Demographic details of families (n=18) who participated in interviews

Sex of child	
Male	11
Female	7
Parents living together	
Always	16
Never	2
Sometimes	0
Mother's employment	
Full -time	4
Part-time	7
Not in paid employment	8
Father's employment	
Full-time	15
Part-time	1
Not in paid employment	2
Deprivation scores	
1-3 (Middle class)	7
4-5 (Working class)	6
6-7 (Deprived areas)	7

	Mean	Range
Age of child (months)	26	17-30
Age of mother (years)	31	21-42
Age of father (years)	33	22-43

LEARNING TO BE A PARENT: DOES THE HEALTH VISITING SERVICE PLAY A PART?

What is the study about?

In order to look at assess the effectiveness of the health visiting service in Edinburgh, research is being carried out to learn about how parent(s) of young children learn about how to manage their child, about how confident they feel as a parent, and about what role the health visitor plays in the process of learning to be a parent.

The study is being funded jointly by Edinburgh Health Care Trust, which employs the health visitors working in Edinburgh, and the Scottish Office; it is being supervised by the Department of Nursing Studies at Edinburgh University.

How was my child's name selected?

The names of children have been provided by Edinburgh Health Care Trust, and has been selected randomly, from first- born children of a similar age. Any information which you provide will be treated in complete confidence, and care will be taken to ensure that it will not be possible to identify any individual in reporting the results of the research.

What will the results be used for?

The results will be used by the health visiting service in order to look at possible changes which would make the service better suited to parents of young children.

Appendix 6: Letter to potential interviewees

*Department of Nursing Studies,
University of Edinburgh,
12 Buccleuch Place,
Edinburgh EH8 9LW*

Tel: 0131 650 8443

Dear ,

Learning to be a parent: does the health visiting service play a part?

I am writing to ask if you would be willing to take part in the research study described in the accompanying information sheet by talking to me about what it is like to be the parent of a young child. I am happy to see you at any time that suits you - during the day, in the evenings or at the weekend. Most parents find it more convenient to talk to me in their own home, though another location, such as a local health centre or child health clinic could be used if you preferred.

If you have any questions about the study, please do not hesitate to contact myself at the above address during office hours. If you would like to speak to someone not directly involved with the research, Sarah Baggaley, Lecturer/ Health Visitor in the Department of Nursing Studies at Edinburgh University would be happy to talk to you (Tel: 650 3888). Both Sarah and I would be happy to telephone you back in order to minimise the expense to yourself.

I shall be in touch with you by telephone in a few days' time.

Yours sincerely,

Rhona Hogg (Research Health Visitor)

Appendix 7: Coding frame for analysis of data

1. Factual details

2. Experience of Parenting

1. Positive
2. Negative
3. Other
4. Expectations
5. Discipline
6. Parents' Own Parenting
7. Father/ Mother specific
8. Confidence
9. Grandparents
10. Previous experience of childcare
11. Aims and Aspirations
12. Experience at different stages

3. Learning to be a Parent

1. By experience
 1. Own
 2. Friends
 3. Family
2. Understanding own child
3. Professionals
4. Books
5. Reassurance
6. Dealing with problems

4. Supports, Surviving, Self-esteem

1. Family
2. Friends
 1. generally
 2. new
3. Work
4. Ready for it
5. Others

5. Health Visiting

1. Positive
2. Negative
3. Understanding of role